HRSA State Planning Grant

Finding and Filling the Gaps:
Developing a Strategic Plan to Cover All Kansans

Report to the Secretary

Grant Period
October 1, 2000 - September 29, 2001
Grantee: Kansas Insurance Department

Executive Summary

Executive Summary

In October 2000, Kansas Insurance Commissioner Kathleen Sebelius was awarded a $1.3 million Health Resources and Services Administration State Planning Grant, as part of a federal initiative to provide states with resources to develop plans to insure that all citizens have access to affordable health insurance. Kansas was among the eleven states initially funded by this program; nine additional states were funded later in 2001.

The grant provided Kansas with funding to collect and analyze data on the state's uninsured and to design a strategy to provide access to affordable coverage and adequate benefits for all its citizens. The specific objectives of the project were:

- To gather detailed, policy relevant demographic and socio-economic data about uninsured Kansans;
- To identify alternative structures and conditions that could motivate Kansas employers to offer coverage to their employees; and,
- To develop alternative approaches to assure health care coverage for Kansans.

The ultimate goal of the project was the development of a five-year plan to cover all Kansans.

The project was planned and overseen by Commissioner Sebelius and her staff, with the assistance of a Steering Committee composed of both public and private stakeholders interested in this issue. Researchers from the University of Kansas Medical Center (KUMC), in cooperation with researchers from the University of Florida, and staff of Bailit Health Purchasing were responsible for conducting the research components of the project.

Previous estimates of the number of uninsured adults and children in Kansas have been relatively low compared to those for other states. In the past, the state has primarily relied on targeted health insurance initiatives and the establishment of the Health Wave program to reduce the number of uninsured citizens. This grant has provided the state with an impetus to begin an effort to ensure that all Kansans have access to affordable health care coverage and with resources to gather data to inform the policy development process.

Project Research Components

The research objectives of the project were accomplished through three components:

- A telephone survey of Kansas households;
- In-depth interviews with uninsured Kansans and with health care professionals who work with the uninsured; and
- Focus groups and interviews with small business owners, insurers, and brokers.

Household Survey

The Kansas Health Insurance Survey was conducted through a collaboration between researchers from KUMC and the Department of Health Services Administration at the University of Florida. Researchers at KUMC directed the survey efforts, and the University of Florida researchers provided technical consultation and analysis and administered the survey. Insurance Commission staff and Steering Committee members provided input and oversight for the survey and all other research components.

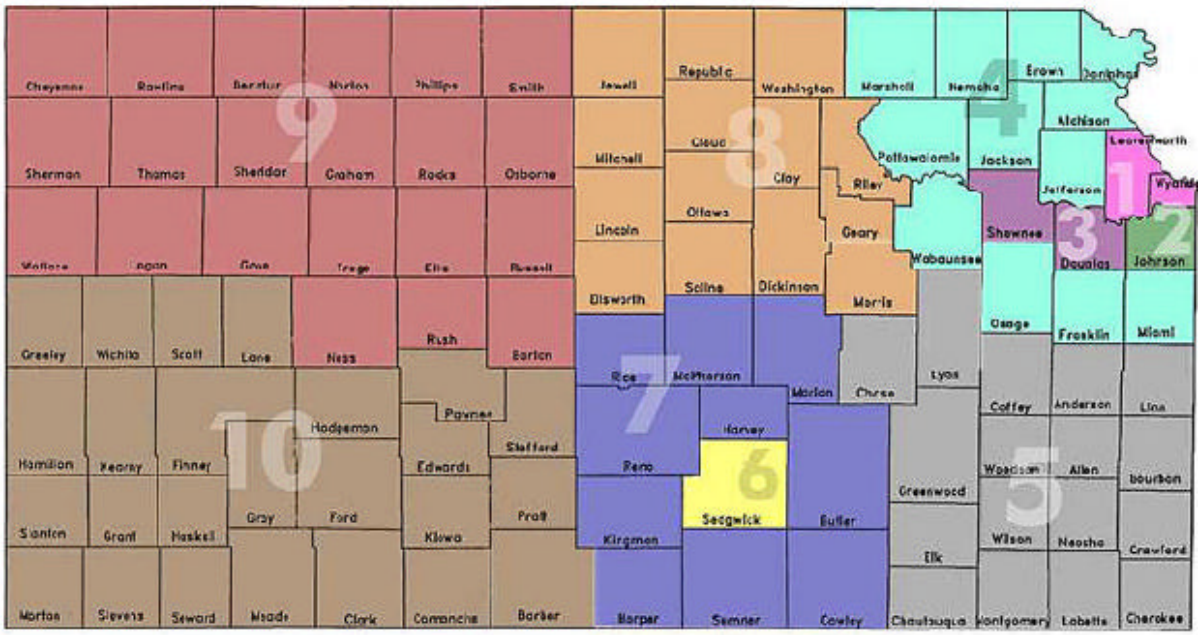
The survey instrument was based on one previously used in similar studies in Florida and Indiana, modified for unique circumstances in Kansas. Fieldwork for the survey was done between March 2001 and June 2001. Telephone interviews were conducted with 8,004 Kansas households (households composed of individuals over age 65 were not included in the survey). These households were comprised of 22,691 individuals. Interviews averaged fifteen minutes in length. Bilingual (English-Spanish) surveyors were part of the University of Florida team, and 180 interviews were conducted in Spanish.

The household survey was intended to gather broad-based information that would enable estimation of differing rates of health insurance coverage among various geographic, demographic, socio-economic, and occupational categories in Kansas. While previous national and Kansas-specific surveys have provided a general overview of the extent of insurance coverage in Kansas and a rough sense of who the state's uninsured are, none of the previous surveys allowed accurate statistical estimates for sub-areas of the state or for various sub-groups. This sort of estimation is important when crafting policy options, since no one solution is likely to work equally well for all parts of the state or all groups within the state. This very large household survey included an adequate number of respondents to make these estimates.

Estimates were developed for ten regions of the state. These regions were selected so that each contained a population large enough to insure valid statistical results and so that each exhibited a population with logical demographic, employment, and marketplace similarities.

Interviews with Uninsured Kansans

The interview component of the research was conducted by KUMC researchers. In-depth, in-person semi-structured interviews were conducted with fifty-seven non-elderly individuals representing fifty households in which at least one person lacked health insurance coverage. In addition, eighteen health care professionals who work with the uninsured were interviewed. These interviews were completed in early 2001. Most interviews were conducted in the interviewees' homes or workplaces. Each interview was audio taped, with the interviewee's permission, and the transcripts were analyzed using accepted qualitative analysis techniques. Spanish language interpreters were available when the interviewee was not fluent in English. Interviews were conducted across the ten regions of the state, presented below.



Through the interviews, the research team sought to discover the reason why Kansans are uninsured, to explore individuals' experiences in trying to obtain health insurance and health care services, and to describe the impact that lack of insurance has for individuals and families. Interviewees were also questioned about their ideas for addressing the problem of the uninsured in the state and for assuring access to affordable health insurance for all Kansas citizens. While the results of the household survey gave us broad-based information about rates of uninsurance and its effects in Kansas, the interviews gave in-depth information about the personal experiences of the uninsured, therefore providing a complementary view of the uninsured in Kansas.

Focus Groups and Interviews with Small Business Owners, Insurers, and Brokers

In April 2001, eight focus groups and twenty personal interviews with small business (less than fifty employees) owners, insurers, and brokers were conducted around the state by staff from Bailit Health Purchasing. Those in the focus groups and those interviewed represented a total of sixty-six small businesses in Kansas. The focus groups and interviews explored the challenges small business owners face in offering health insurance coverage as a benefit to workers and their dependents. This was an especially important group to address in this research. Small employers are less likely to offer health insurance coverage to workers and are more at risk for large, sometimes unanticipated, premium increases than are large businesses.

Conclusions from Research

While the percentage of Kansans who lack health insurance is low relative to that in other states, a substantial number of Kansans remain uninsured and therefore have limited access to health care services needed to maintain and improve their health. The rate of uninsurance in Kansas varies greatly across geographical areas and across population subgroups. Due to this variation, a number of targeted solutions crafted to fit various geographic, demographic, socio-economic, and occupational subgroups will be needed so that all Kansans have access to affordable comprehensive health care coverage.

Because most of the uninsured are employed but earn relatively low incomes, subsidies in some form will be required to help these individuals and families gain access to health insurance. Employment-based insurance is clearly the foundation of health insurance coverage in the state, as well as in the nation. Therefore, proposed solutions to the problem of the uninsured should build on this foundation and find ways to enable workers to access the coverage offered by their employers and also to make it more possible for employers to offer coverage to workers. Special attention will need to be paid to small businesses, since they are currently less likely to provide health insurance coverage to their employees and are the most likely to be influenced by premium increases.

Public programs, like Health Wave and Medicaid, have been very successful in providing health insurance coverage to Kansas children. Ways to enhance and expand these programs should be explored, thereby maximizing the use of federal dollars and leveraging state dollars so they can do the most good.

Current Status of Project

The Steering Committee is currently reviewing the results of the three research components and using those results as a foundation for development of a plan to cover all Kansans. In addition, input from Kansans is being obtained through a series of public meetings being held across the state.

A variety of policy options are under review. These include:

- Expansion of public programs (Medicaid, HealthWave)
- Facility-based insurance
- A state health reinsurance market tool
- An enhanced small employer tax credit program
- Expanding access to employer-sponsored health insurance through Medicaid and HealthWave
- Regulatory changes
- State employee health plan expansions

In addition, the Steering Committee is monitoring development of the state's business-health partnership. The partnership will included in the Committee's plan development as appropriate.

Finding and Filling the Gaps:
Developing a Strategic Plan to Cover All Kansans

Report to the Secretary

Section I
Summary of Findings:
Uninsured Individuals and Families in Kansas

Questions 1.1 through 1.3

Source of Information
Kansas Health Insurance Survey--a telephone survey of 8,004 Kansas households (representing 22,691 non-elderly individuals) completed in 2001.

1.1 What is the overall level of uninsurance?

Overall, 10.5% (224,880) of Kansans under age 65 are without health insurance. .

1.2 What are the characteristics of the uninsured?

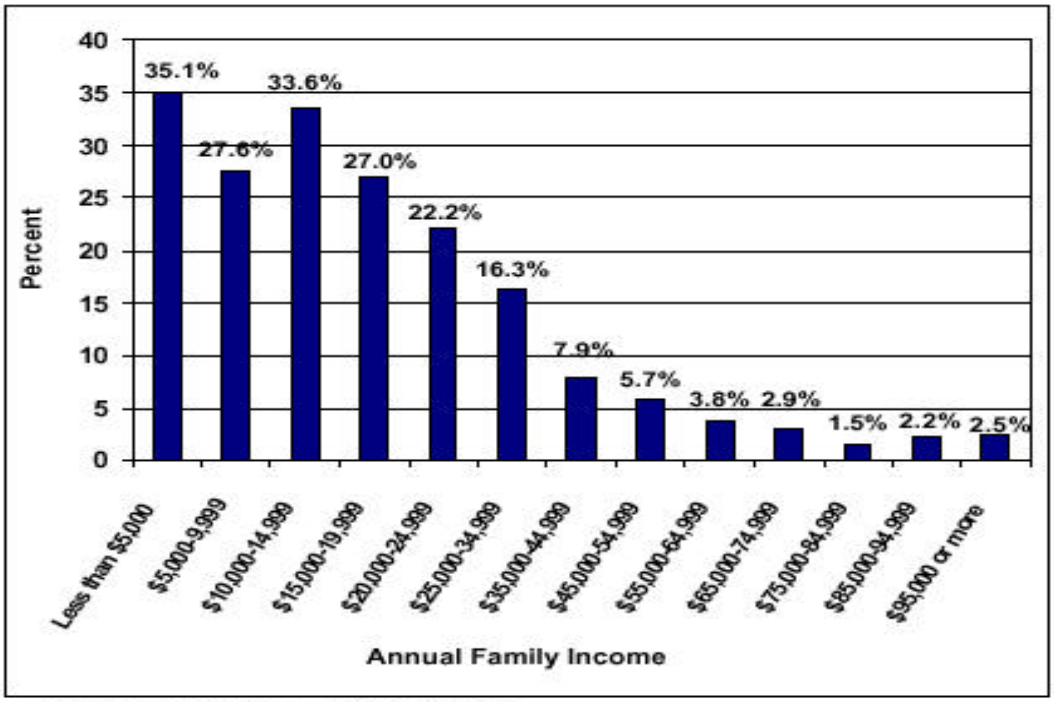
Income

Individuals in Kansas families with lower incomes are more likely to be uninsured.

- In the three lowest categories of annual family income (less than $5,000; $5,000 to $9,000; and $10,000 to 14,999), the percentage of those without insurance is the highest, at 35.1%, 27.6%, and 33.6%, respectively.

- In the three highest annual family income categories, percentages of the uninsured are the lowest: 1.5% in the $75,000-84,999 bracket, 2.2% in the$85,000-94,999 bracket, and 2.5% in the greater than $95,000 bracket.

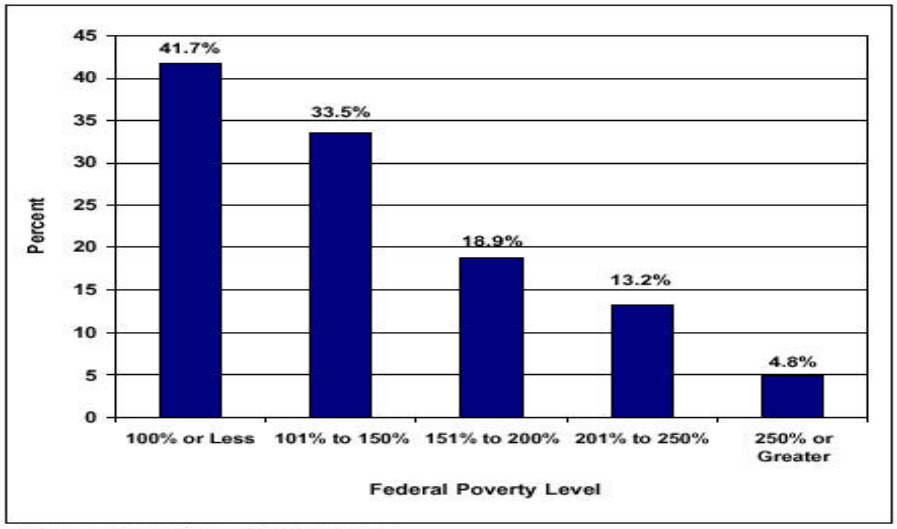
Figure 1.1: Percent of Kansans under Age 65 Who Are Uninsured by Annual Family Income



Sample size for this figure = 19,927 individuals

- Similarly, 41.7% of adults living at or below 100% of the Federal Poverty Level (FPL) are uninsured, compared to only 4.8% of those with income at 250% of the FPL or greater.

Figure 1.2: Uninsured Kansans Age 19-64 by Income as a Percent of Federal Poverty Level (FPL).

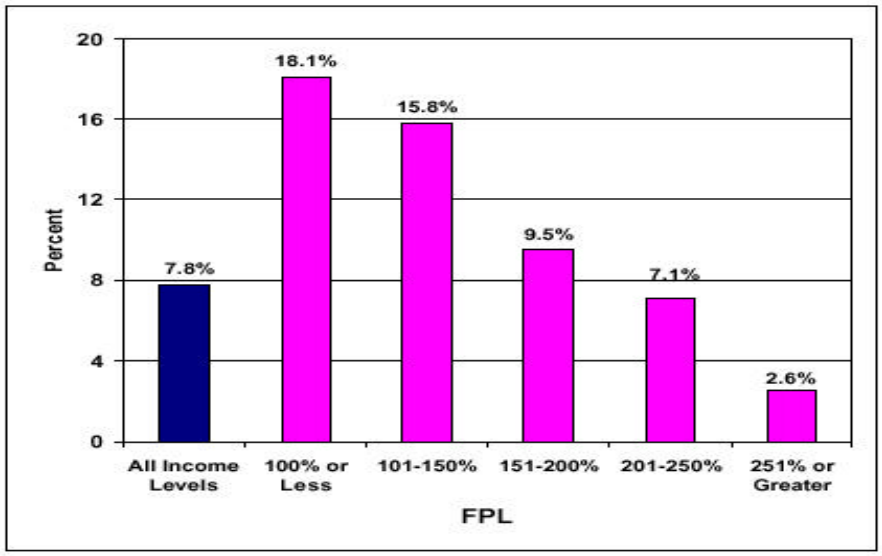


Sample size for this figure = 13,119 individuals

- The highest rate of uninsurance for Kansas children, at 18.1%, is in families living at or below 100% FPL.

- Uninsurance for children, just as with all Kansans under age 65, declines as income increased, with only 2.6% of children in families with incomes at 251% of FPL or greater lacking health insurance.

Figure 1.3: Percent of Uninsured Kansas Children Under Age 19 by Income as a Percent of Federal Poverty Level (FPL).



Sample size for this figure = 6,761 individuals

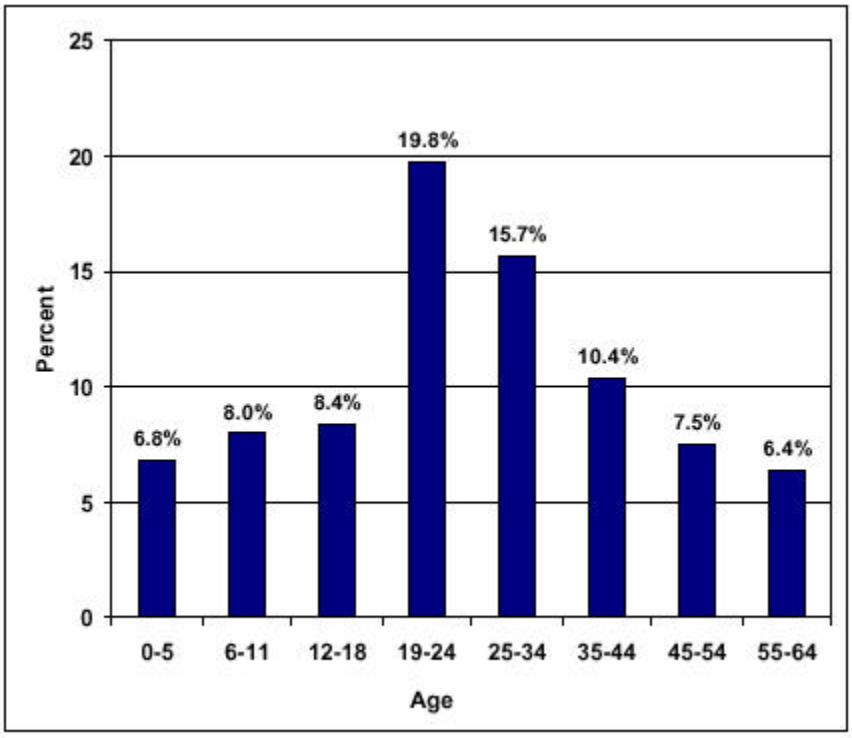
Age

- Statewide, the highest rate of uninsurance (19.8%) is among young adults, aged 19-24.

- The percent of uninsured, non-elderly adults declines with age, with those individuals aged 55-64 years having the lowest percent of uninsured (6.4%).

- Children have relatively low rates of uninsurance, with infants to 5 years at 6.8%, those 6 to 11 years at 8.0%, and preadolescents/adolescents slightly higher at 8.4%.

Figure 1.4: Uninsured Kansans Under Age 65 Specific Age Category.



Sample size for this figure = 22,180 individuals

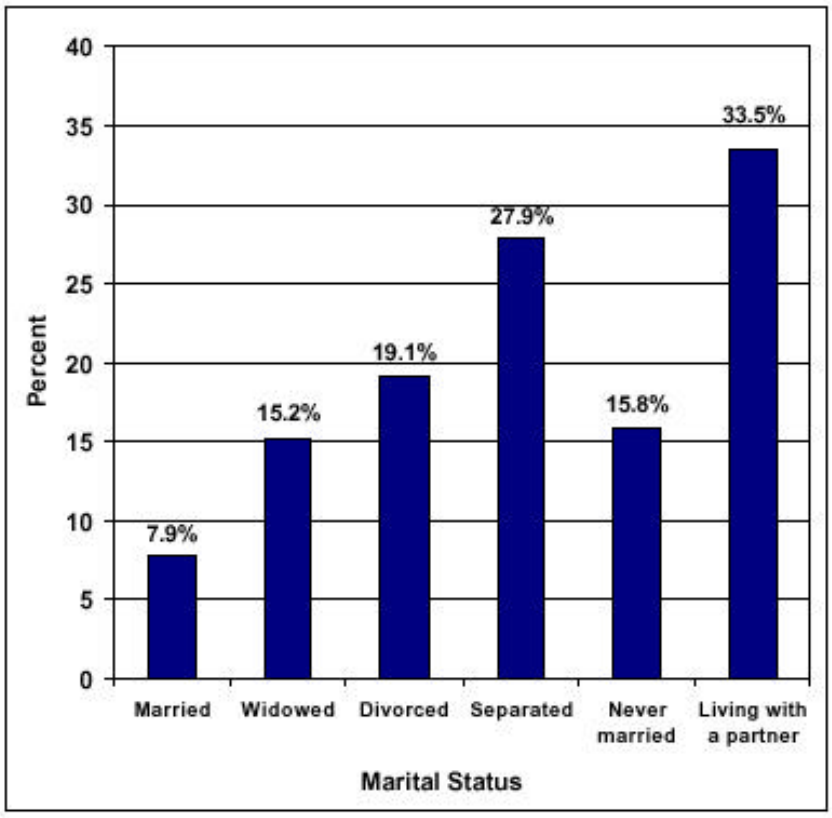
Gender

There is little difference in rate of uninsurance between men and women in Kansas, with 10.7% and 10.4% of men and women, respectively, who are uninsured.

Family composition

- Married individuals have the lowest rate of uninsurance, at 7.9%.
- Those who are unmarried but living with a partner have the highest rate of uninsurance, at 33.5%.
- Those who are separated have the next highest uninsurance rate, at 27.9%; widowed, divorced, and those never married have rates ranging from 15.2% to 19.1%.

Figure 1.5: Percent of Uninsured Kansans Age 16-64 by Marital Status.



Sample size for this figure = 16,247 individuals

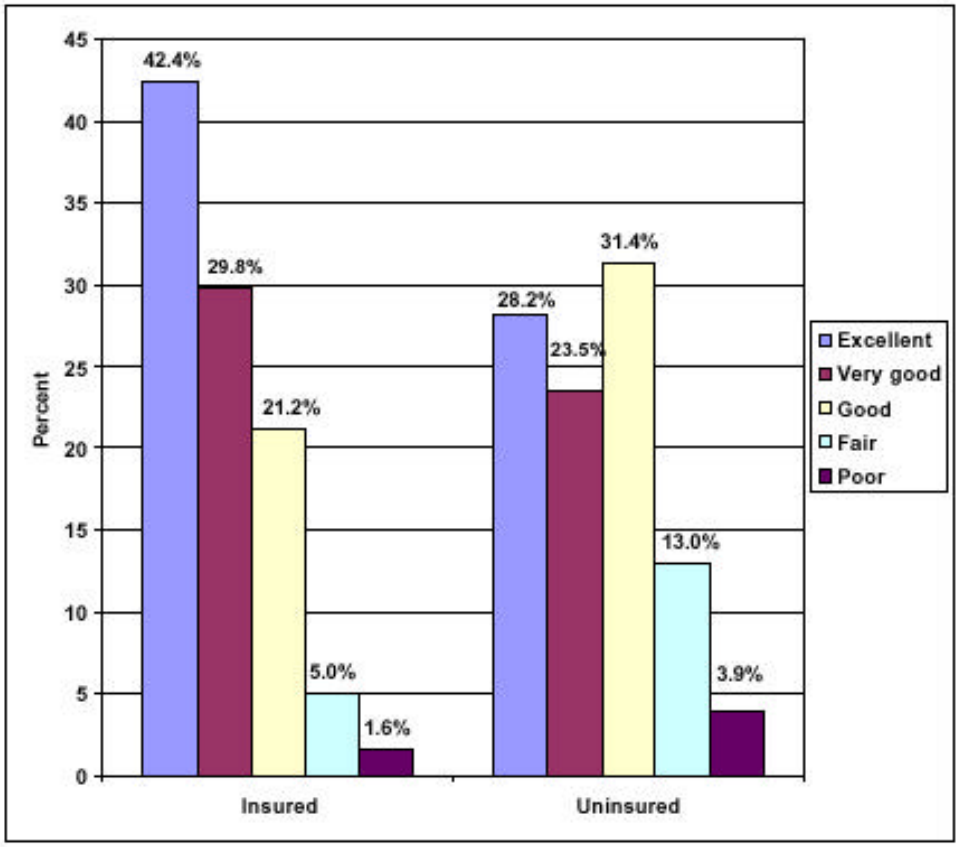
Health status

In general, people with health insurance tend to view their health as better than those without health insurance.

- About 42% of insured Kansans under age 65 reported they are in excellent health. By contrast, only 28.2% of uninsured Kansans under age 65 report themselves to be in excellent health.

- Almost 17% of uninsured Kansans report their health as fair or poor, while 6.6% of insured Kansans report fair or poor health.

Figure 1.6: Perceived Health Status and Insurance Status of Kansans Under Age 65.



Sample size for this figure = 22,405 individuals

Employment status

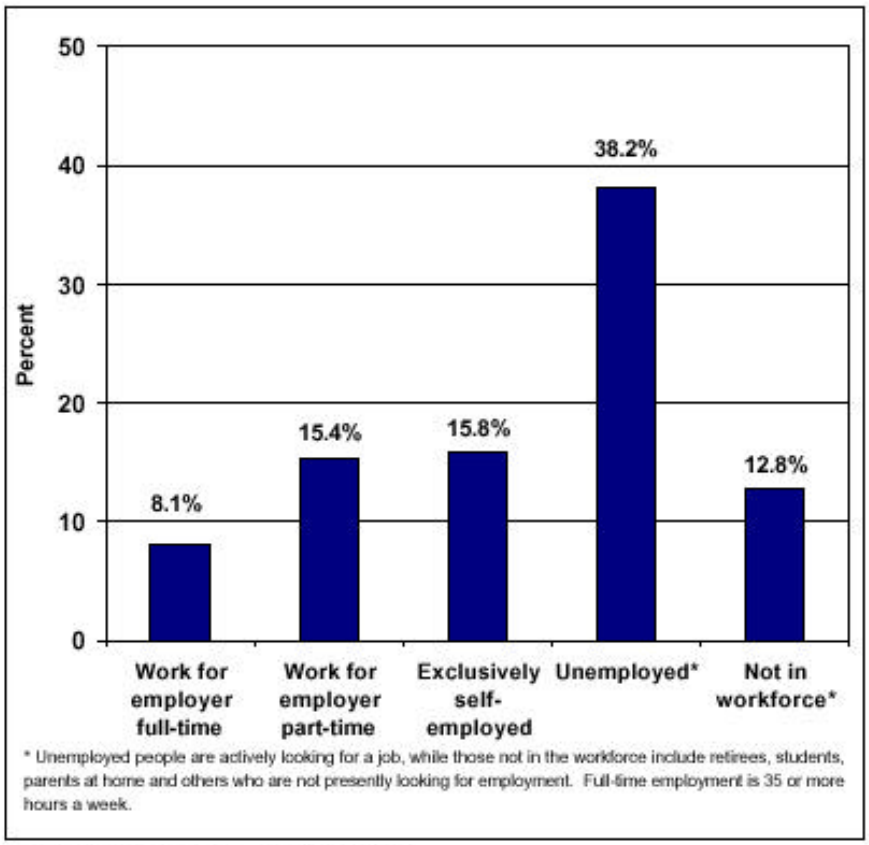
In Kansas, employment status and health insurance coverage are strongly associated.

- The highest rate of uninsurance for Kansans, related to employment circumstances, is for the unemployed, at 38.2%.

- By contrast, only 8.1% of those who work for an employer full-time are uninsured.

- Uninsurance rates increase for Kansans if the individual works part-time or is self-employed individuals, to 15.4% and 15.8%, respectively.

Figure 1.7: Uninsured Kansans Age 18-64 by Employment Status



Sample size for this figure = 15,329 individuals

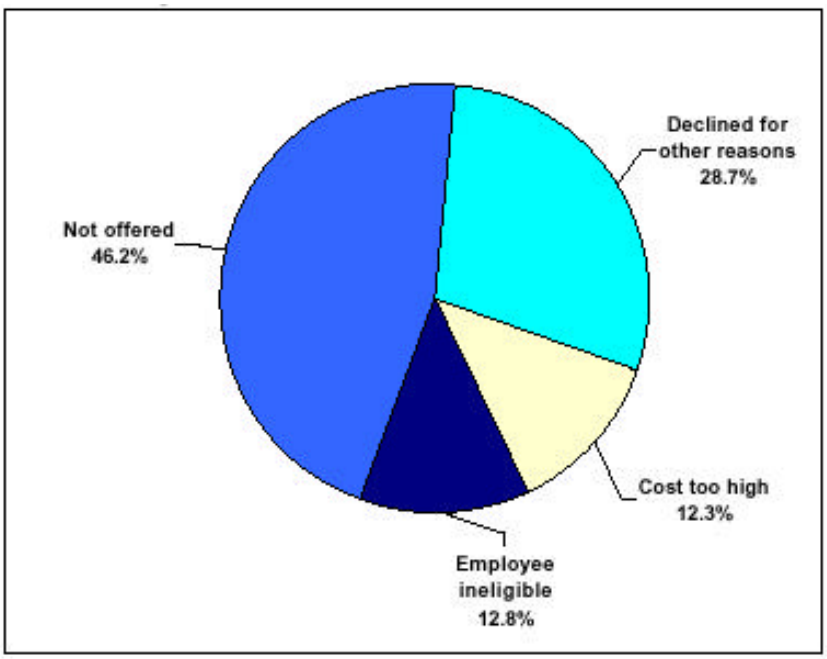
Availability of private coverage

- Approximately, 46% of uninsured, employed Kansans, aged 18-64 years, work for employers that do not offer health insurance.

- Another 12.8% work for employers that offer health insurance but for which they are not eligible.

- About 41% of uninsured, employed Kansans have employers who offer insurance that they decline, either because the cost is too high or for other reasons.

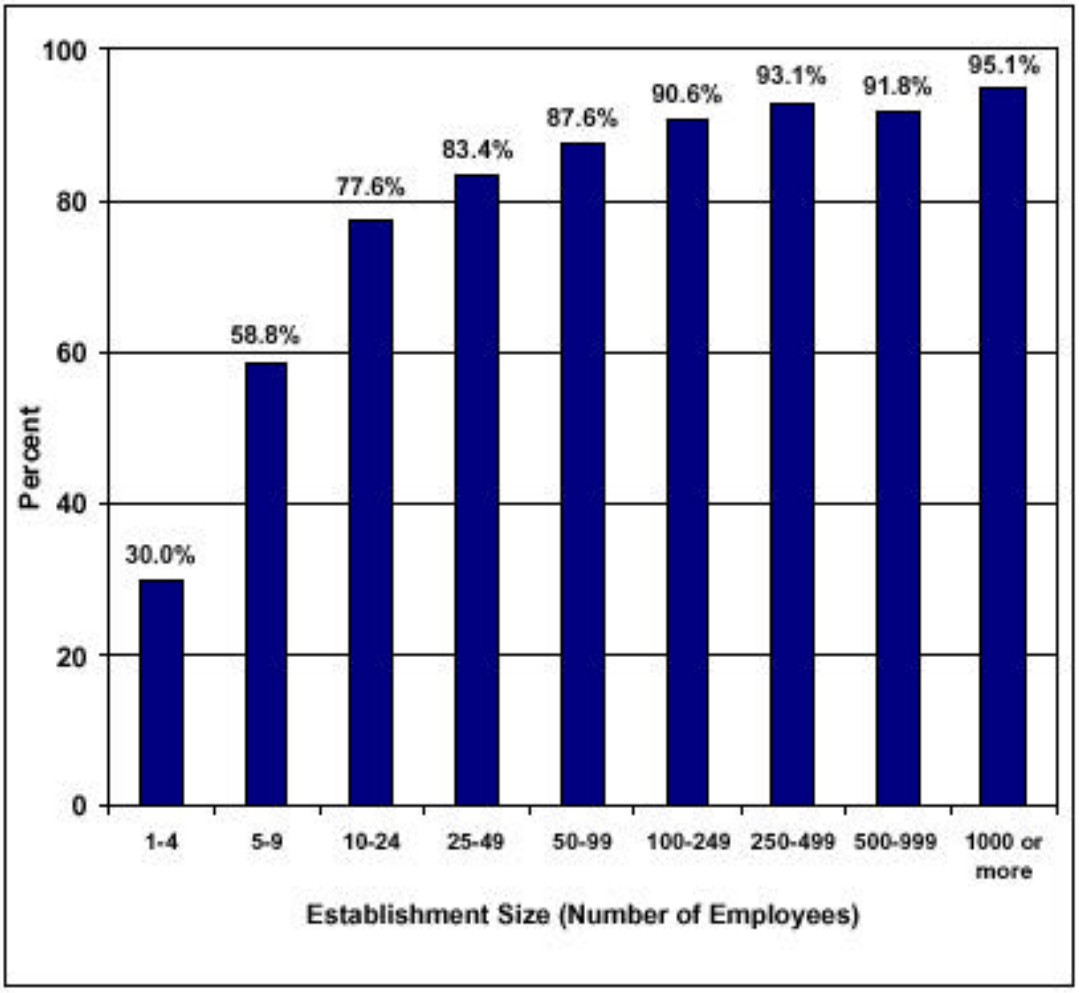
Figure 1.8: Availability of Employment-Based Health Insurance for Uninsured Employed Kansans Age 18-64.



Sample size for this figure = 1,124 individuals

- Most Kansans (over 70%) obtain their health insurance coverage through employment. Employers of larger employers are more likely to be offered insurance than those who work for smaller establishments. Statewide, over 95% of those who work for establishments with more than 1,000 employees report that their employers offer health insurance coverage. By contrast, only 30% of those in establishments with four or fewer employees report that their employers offer health insurance as a benefit.

Figure 1.9. Percent of Employed Kansans Age 18-64 Offered Health Insurance by Their Employer, by Their Employer Establishment Size.



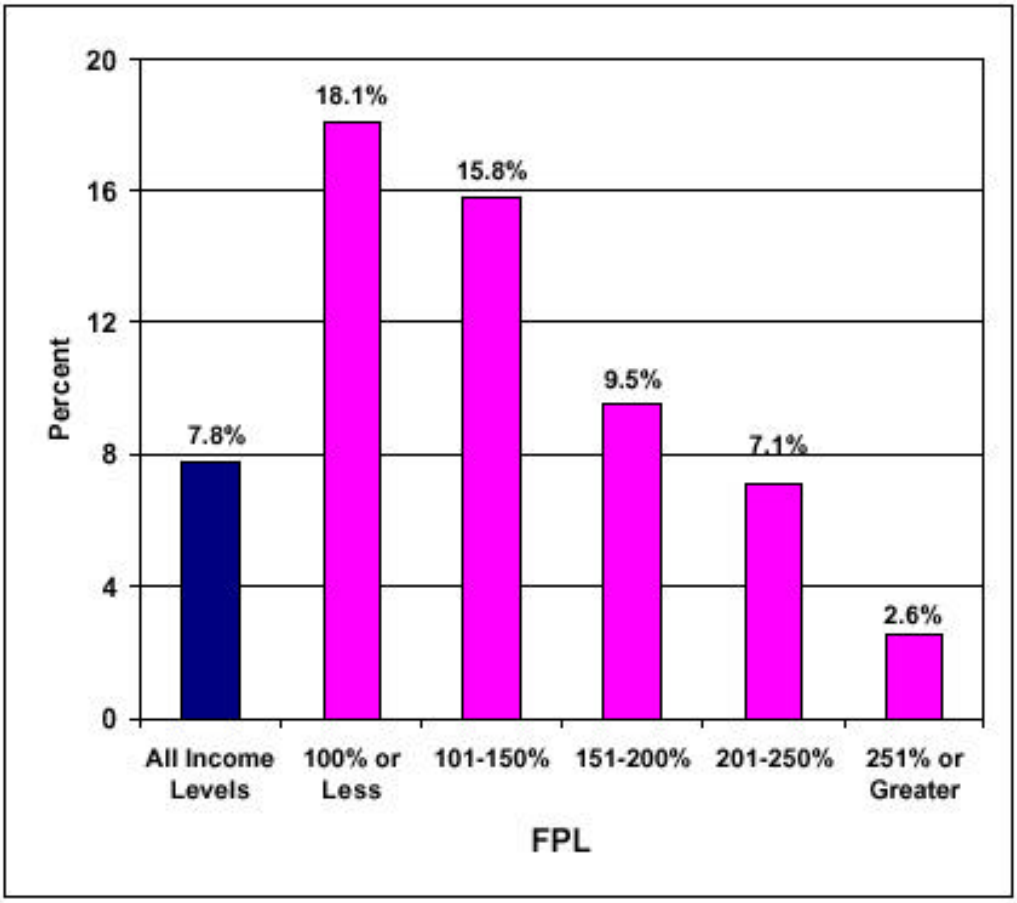
Sample size for this graph = 10,164 individuals

Availability of public coverage

- Statewide, 41.7% of adults, aged 19-64, with incomes at or below 100% of the FPL are uninsured (See Figure 1.2).

- Although this percentage is considerably lower for children, at 18.1%, this is still of concern.

Figure 1.10: Percent of Uninsured Kansas Children under Age 19 by Income as a Percent of Federal Poverty Level (FPL).

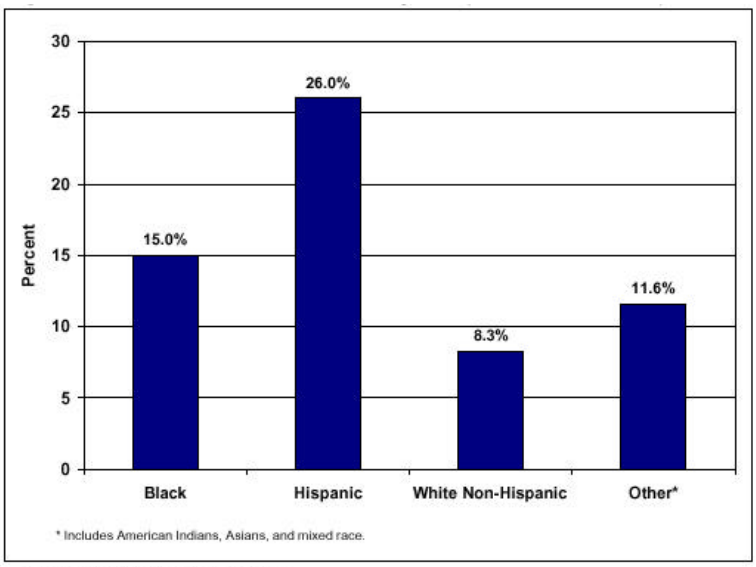


Sample size for this figure = 6,761 individuals

Race/ethnicity

- Statewide, Hispanics have the highest rate of uninsurance, at 26.0%.
- The lowest rate of uninsurance is for white non-Hispanics, at 8.3%.
- The uninsurance rate for African-Americans is 15.0%, and the rate is 11.6% for other ethnic and racial groups (Native American, Asian, and mixed race).

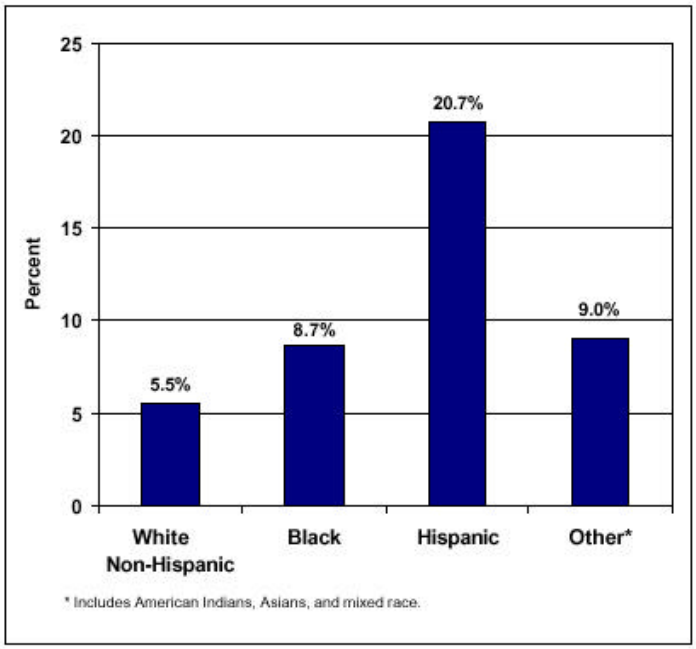
Figure 1.11: Uninsured Kansans under Age 65 by Race and Ethnicity.



Sample size for this table = 22,121 individuals

- Among children, Hispanics have also the highest rate of uninsurance, at 20.7%, with rates African-Americans, other racial/ethnic groups, and white, non-Hispanics at 8.7%, 9.0%, and 5.5%, respectively.

Figure 1.12: Uninsured Kansas Children Under Age 19 by Race and Ethnicity.



Sample size for this figure = 7,366 individuals

Immigration status

This information was not solicited in the survey.

Geographic location

Rates of uninsurance vary substantially across the 10 regions of the state described above.

- The highest percentages of uninsured, at 16.8% and 16.4%, are in Region 10 (southwest Kansas) and Region 1 (Leavenworth and Wyandotte counties), respectively.

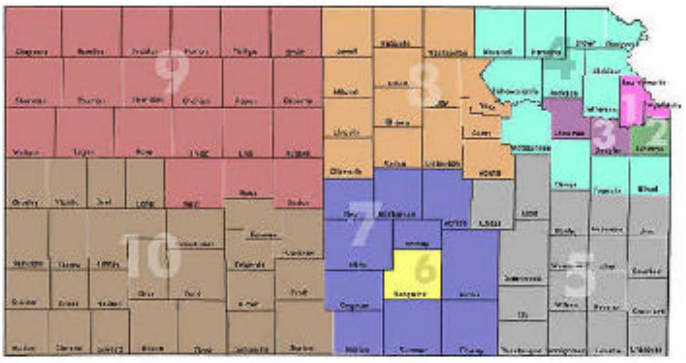
- Region 10 (24 southwest counties), with the highest overall uninsurance rate, also has the highest uninsurance rate for adults (19.6%) and the second highest for children (11.9%)

- The lowest rate of uninsurance in Kansas is in Region 2 (Johnson County), at 5.4%. Region 2 also has the lowest rate of uninsurance for adults, at 5.7%, but only the third lowest for children, at 5.1%.

Table 1.1: Uninsured Kansans under Age 65, Statewide and by Region.

	Percent Uninsured
Kansas	**10.5**
Region 1	16.4
Region 2	5.4
Region 3	9.3
Region 4	6.7
Region 5	12.8
Region 6	11.5
Region 7	10.9
Region 8	9.9
Region 9	9.4
Region 10	16.8

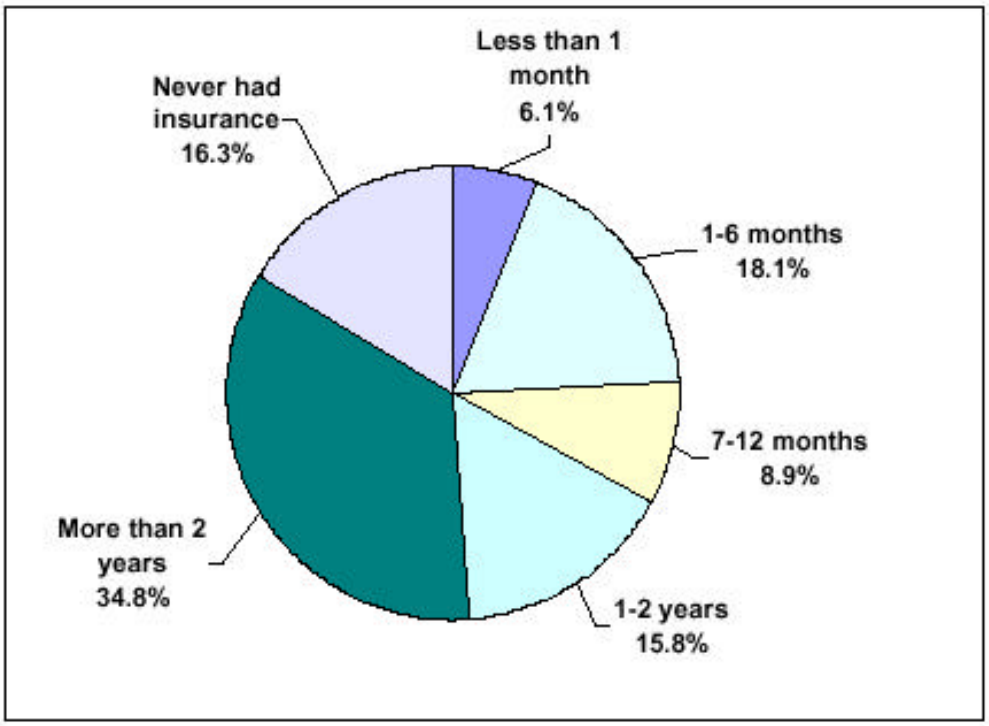
Sample size for this table = 22,479 individuals



Duration of Uninsurance

- More than half (51.1%) of the uninsured in Kansas have never had insurance or have been uninsured for more than 2 years.

Figure 1.13: Length of Time Without Health Coverage, Uninsured Kansans under Age 65.



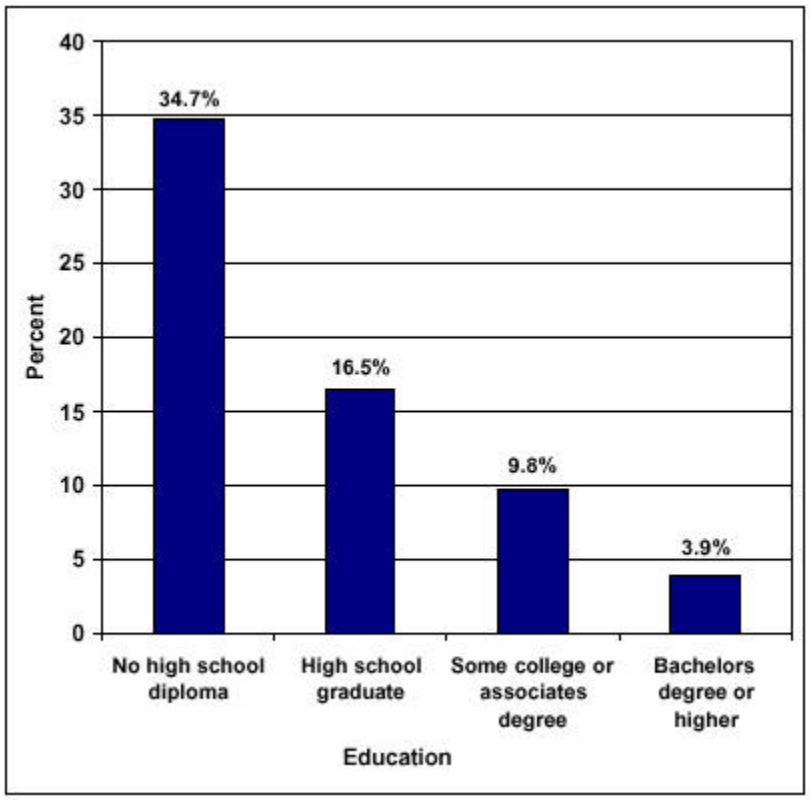
Sample size for this table = 2,114 individuals.

Education

The rate of uninsurance for Kansans declines as education level increases.

- Adults without a high school diploma have the highest rate of uninsurance at 34.7%.
- Adults with a bachelor's degree or higher have the lowest rate (3.9%).

Figure 1.14: Uninsured Kansans Age 18-64 by Education.



Sample size for this figure = 15,209 individuals

1.3 What population groupings are particularly important in developing targeted coverage expansion options?

- Those who are employed but not currently insured, particularly those who work for small employers and/or are employed in low wage jobs.
- Adults in the 19-24 age group.
- Children who are eligible for public coverage but are not currently enrolled.
- Uninsured parents of children who are enrolled in public programs.
- Minority groups.

Questions 1.4 through 1.13

Source of Information
Voices of the Uninsured: Kansans Tell Their Stories and Offer Solutions--a qualitative study with data collected through key informant interviews with 57 non-elderly individuals, representing 50 Kansas households.

1.4 What is affordable coverage? How much are the uninsured willing to pay?

- Respondents believe that insurance cost should be based on a percentage of income.
- They also believe that there should be limits on "out of pocket expenses" for health care including deductibles and co-pays and that health insurance should cover some portion of prescription costs.
- The majority of respondents indicated a willingness to pay $50 to $86/month (response range $0 to $300).

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

- The majority of uninsured participants either did not think they were eligible or were told they were ineligible for public insurance. Many participants stated there was no public insurance for the "working poor." Almost all participants' children under 18 were enrolled in either HealthWave (SCHIP) or Medicaid.
- Uninsured interview participants expressed concern about the stigma attached to public insurance for adults as well as the intrusiveness and complexity of the enrollment process. Still, almost all but a few of the interviewees would enroll in Medicaid or an SCHIP-type program if they were eligible.
- The majority of interview participants found the Kansas HealthWave program much more accessible than the Medicaid program.

1.6 Why do uninsured individuals and families disenroll from public programs?

We did not specifically explore public program disenrollment from public programs in our interviews.

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

- More than two-thirds of employed interview participants were either ineligible for their employer's coverage or did not have employer sponsored coverage available to them. This lack of availability of employer health coverage for the uninsured was also found in our household survey, with 46.2% of uninsured who are employed not offered insurance and another 12.8% ineligible for offered coverage.

- For those interview participants who had employer coverage offered, the primary reason for not participating was cost. Most felt that the insurance cost was unaffordable on their budget, in part because most had low wages ($7 - $8/hour). Many had incurred medical bills due to being uninsured that made it difficult for them to pay past medical bills and also pay insurance premiums..

1.8 Do workers want their employers to play a role in providing insurance? Would some other method be preferable?

- Overwhelmingly, uninsured interview participants indicated a preference for employer-sponsored insurance benefits. Most interviewees thought employers should provide a health insurance benefit for all their employees, including those who work part-time.

- A number of participants believed that access to public insurance should be expanded to include the "working poor," persons, like themselves, who have low wage jobs or are working part-time.

1.9 How likely are individuals to be influenced by:

Subsidies?

Several participants recognized that for insurance to be affordable for them there needed to be some mechanism to subsidize the cost. Few had ideas about how that subsidy would be financed.

Tax credits or other incentives?

Few saw any value to tax credits; their income was so low that credits like that were meaningless to them personally.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

- Interview participants described access to insurance as a significant barrier. The most common access complaint was for employer-sponsored insurance. About two-thirds of participants who worked had no available employer health insurance benefit, either

because they were ineligible for coverage that was offered or because coverage was not offered by their employer. In addition, several participants discussed inability to purchase private insurance on an individual basis due to pre-existing medical problems.

- Participants also discussed the lack of affordable and adequate health care as another key barrier to purchasing health insurance. Participants described a complex cycle of illness or injury, followed by medical debt incurred to get adequate care. Sometimes the illness or injury led to the loss of their job and lowered income, resulting in less income to buy insurance. Even for those who kept their jobs, the money required to pay their medical bills left less discretionary income with which to buy insurance.

1.11 How are the uninsured getting their medical needs met?

- Uninsured participants described a "patchwork" of available, affordable care. Many said that they accessed medical care in the safety-net clinics that are funded through federal and state grants, as well as through local funds and in-kind services.

- Since the safety-net clinics provide only primary care, participants discussed problems in obtaining hospital and specialty care, as well as pharmaceuticals.

- Many participants counted on their local hospitals, particularly in rural and frontier counties, for emergency or acute care, and basically tried to "get by" without primary or preventive services.

- Participants hoped they would stay healthy or would try to find piecemeal inexpensive care when it was needed.

The household survey provides additional information on health utilization and sites where uninsured go for health care services.

- Individuals who have health insurance are more likely to have a usual source of care (87%) than the uninsured (67.4%).

- In addition, people without insurance were less likely to have a doctor or clinic visit in the last 6 months (53.3%) than those who are insured (29.1%).

- Uninsured Kansans were more likely to delay needed care within the last 12 months due to financial barriers (40.8%) than the insured (8%).

1.12 What do the uninsured in Kansas consider a minimum benefit?

- Uninsured participants explained that if they were to purchase health insurance it was important that the benefit protect them from most of the potential out-of-pocket expenses for health care.

- Because most live on a very limited budget, if they were to add a health insurance premium cost to their monthly expenses, they would have little left to cover out-of-pocket medical expenses. Therefore, the insurance would have to have very low or no deductible expense, would have to cover at least a portion of pharmacy costs, and would have to keep co-pays to a minimum, e.g. $10.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

We did not explore the concept of underinsurance, either in the qualitative or quantitative studies.

Section II
Summary of Findings:
Employer-Based Coverage

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Source of Information
Kansas Health Insurance Survey

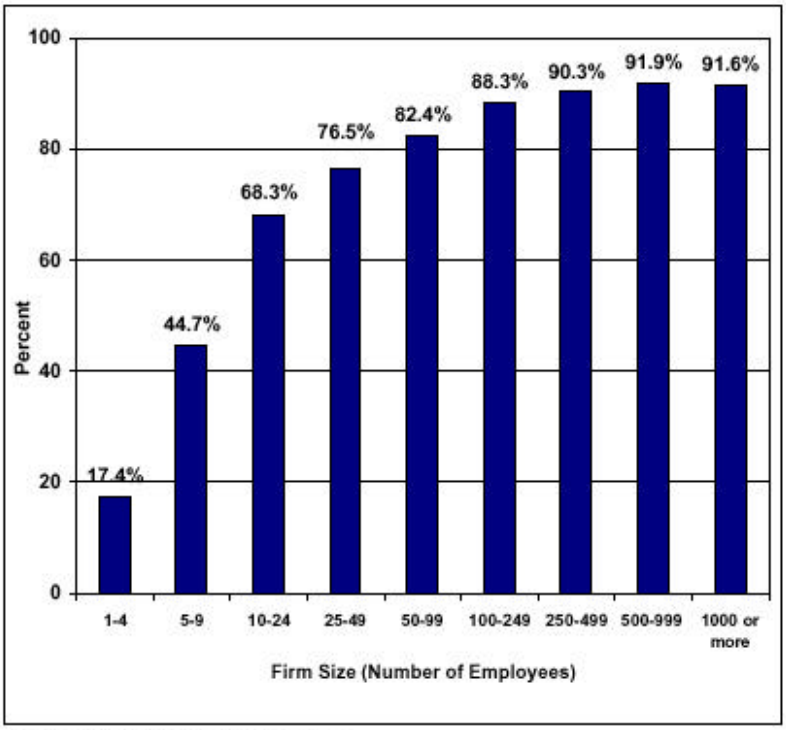
Employer size

Employees of larger employers are more likely to be offered health insurance than those who work for smaller firms:

- Statewide, 91.6% of individuals who work for firms with 1,000 or more employees report that their employer offers health insurance to at least some of their employees.

- By contrast, only 17.4% of those in firms with four or fewer employees report that their employer offers health insurance to at least some of their employees.

Figure 2.1: Percent of Employed Kansans Age 18-64 Offered Employment-Based Health Insurance, by Their Employer's Firm Size.



Sample size for this figure = 9,705 individuals

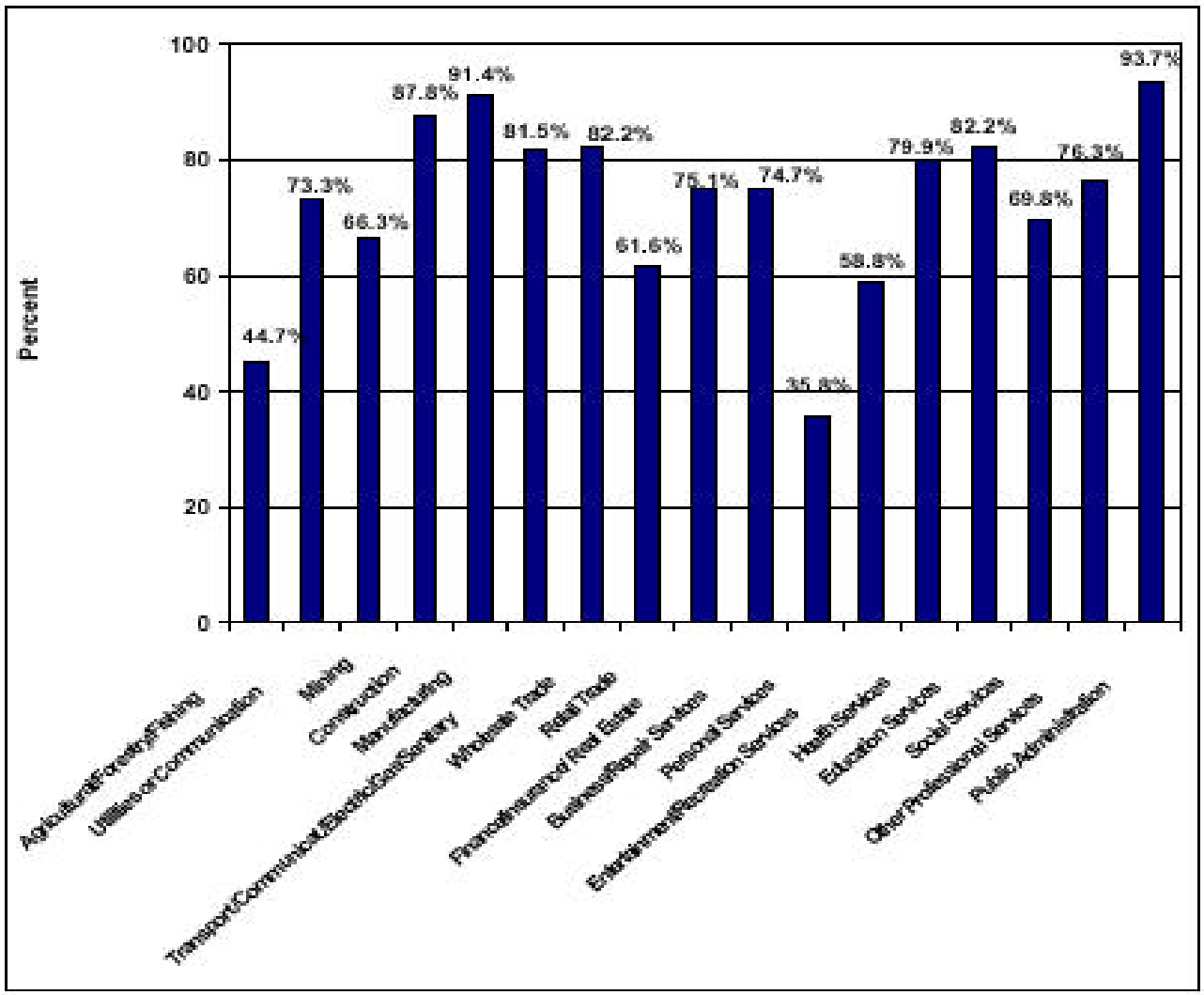
Industry sector

- Workers employed in the personal services sector (e.g., barbers, child care, dry cleaners) are least likely to report that their employer offers health insurance (35.8%).

- The highest rates of coverage were reported in public administration (93.7%), manufacturing (91.4%), and construction (87.8%).

- By contrast, workers in agriculture (44.7%), entertainment and recreation services (58.8%), and retail trade (61.6%) reported somewhat low offers of employment-based employer-sponsored health insurance.

Figure 2.2: Percent of Employed Kansans Age 18-64 Offered Health Insurance By Their Employer by Type of Industry.

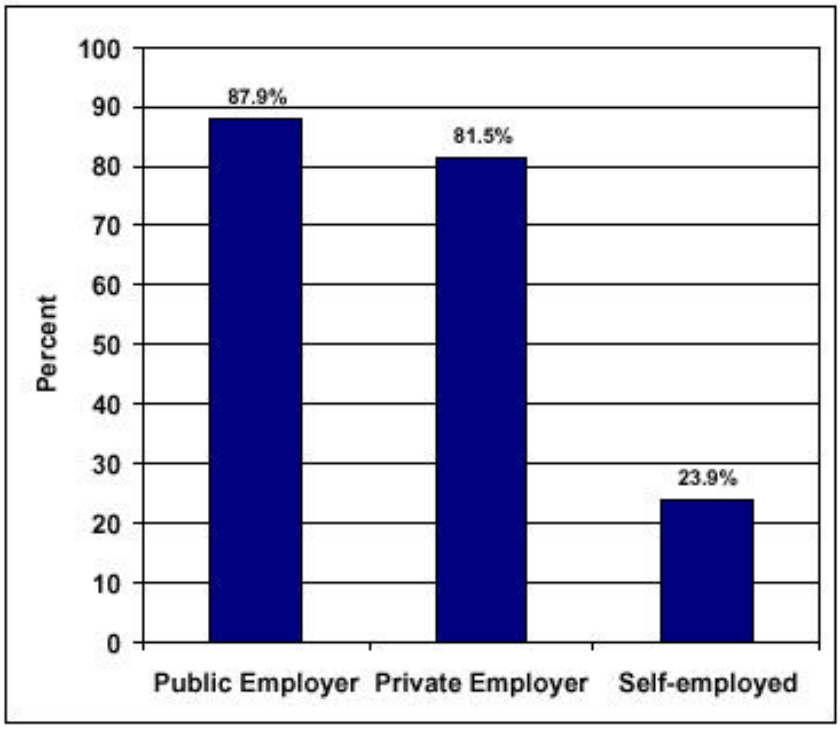


Sample size for this graph = 10,730 individuals

- Employees who work for public employers are more likely to report that their employer offers health insurance (87.9%) than employees who work for private employers (81.5%).

- Less than a quarter (23.9%) of those who are self-employed report that they have health insurance through their businesses.

Figure 2.3: Percent of Employed Kansans Age 18-64 Offered Health Insurance by Their Employer by Employer Sector.



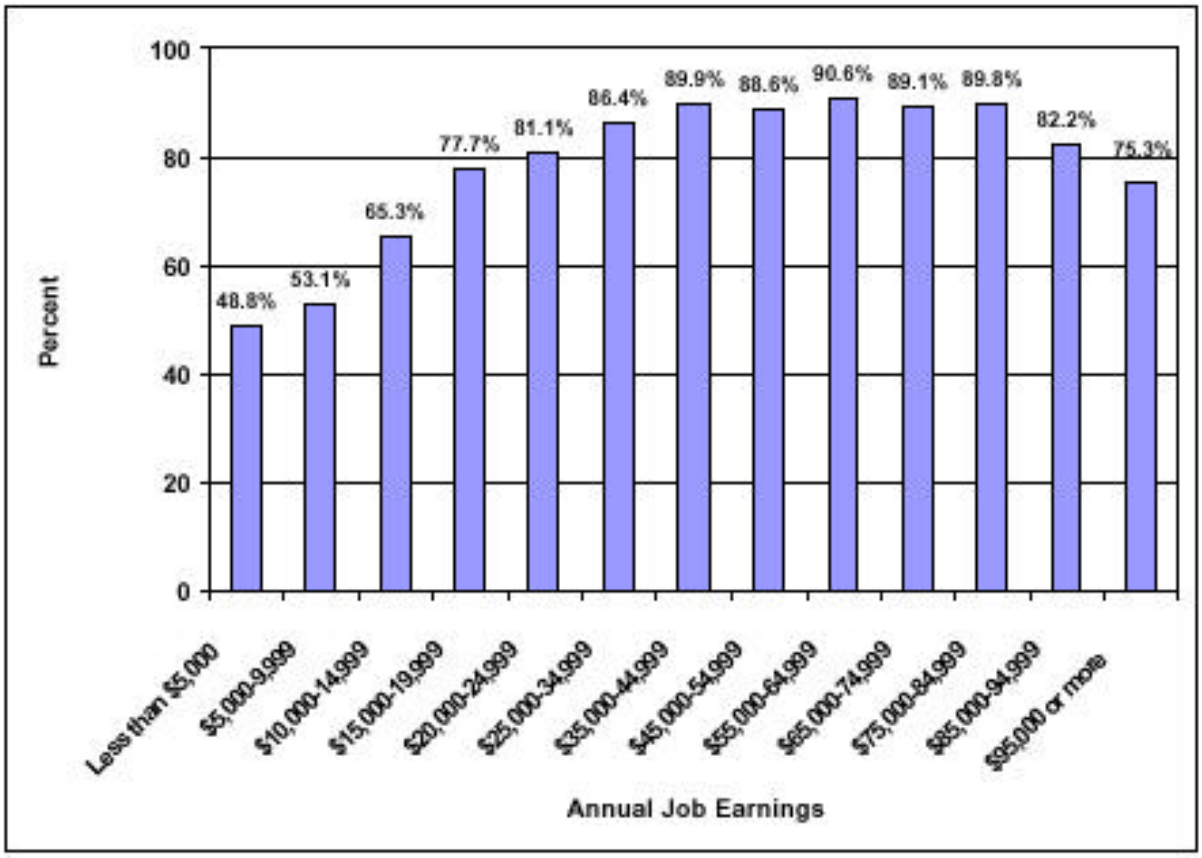
Sample size for this figure = 10,546 individuals

Employee income brackets

In general, workers with higher job earnings are more likely to report that their employers offer health insurance.

- About 49% of those earning under $5,000 annually report that their employers offer health insurance.
- By contrast, over 80% of employees with annual earnings over $20,000 said that their employers offer health insurance coverage to at least some of their employees.

Figure 2.4: Percent of Employed Kansans Age 18-64 Whose Employer Offers Health Insurance to at Least Some of Their Employees, by Job Earnings.

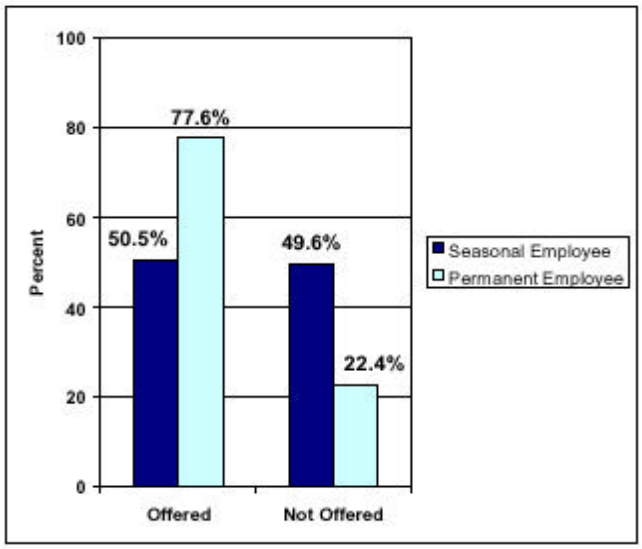


Sample size for this figure = 8,651 individuals

Percentage of part-time and seasonal workers

- Permanent employees are more likely to report being offered health insurance by their employer (77.6%) than are seasonal workers (49.6%).

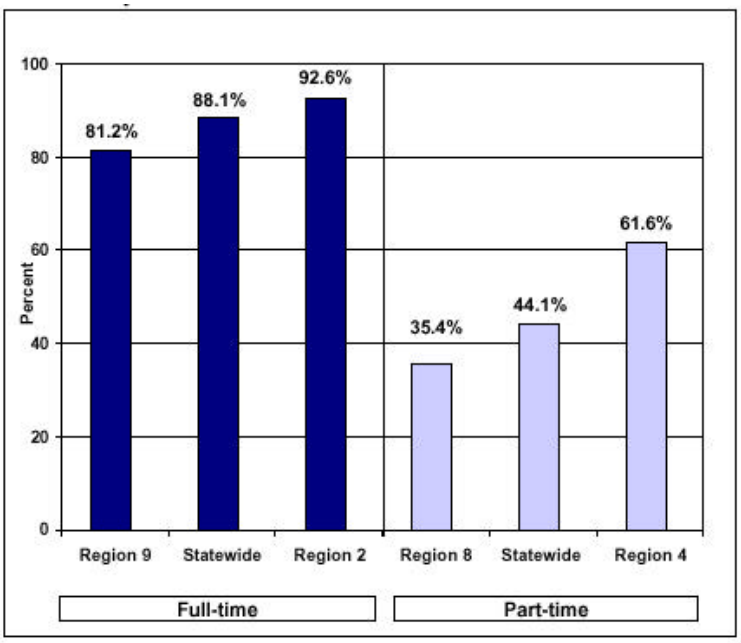
Figure 2.5: Percent of Employed Kansans Age 18-64 Offered Health Insurance by Their Employer by Employment Seasonal Status.



Sample size for this figure is 10,784 individuals

- Only 44.1% of persons employed less than full-time (less than 35 hours per week) reported their employer or union offers health insurance compared to 88.1% of full-time workers with health benefit offers from their employer or union.

Figure 2.6: Percent of Employed Kansans Age 18-64 Offered Health Insurance by Their Employer by Full Time and Part Time Employment, Statewide and by Range of Geographic Variability.



Sample size for this figure = 8,238 full-time workers, 1,177 part-time workers

Geographic location

- The percentage of employed Kansans who reported that their employer offers health insurance coverage ranges from a low of 68.1% in Region 9 (northwest portion of Kansas) to a high of 85.1% in Region 2 (Johnson County).

Table 2.1: Percent of Employed Kansans Age 18-64 Who Report that Their Employer Offers Health Insurance Coverage, Statewide and by Region.

	Employer Offers Coverage Percent
Kansas	**80.6**
Region 1	81.6
Region 2	85.1
Region 3	83.5
Region 4	79.2
Region 5	77.5
Region 6	83.9
Region 7	80.5
Region 8	78.0
Region 9	68.1
Region 10	72.5

Sample size for this table = 10,852 individuals

- The availability of health insurance for part-time employees differs among state regions, with a low of 35.4% in Region 8 (north central Kansas) to a high of 61.6% in Region 4 (northeast Kansas). (See Figure 2.6).

For employers offering coverage:

Source of information:
Kansas Health Insurance Survey
This information is from the employee perspective, since no large-scale survey of Kansas employers was completed as a part of this project.

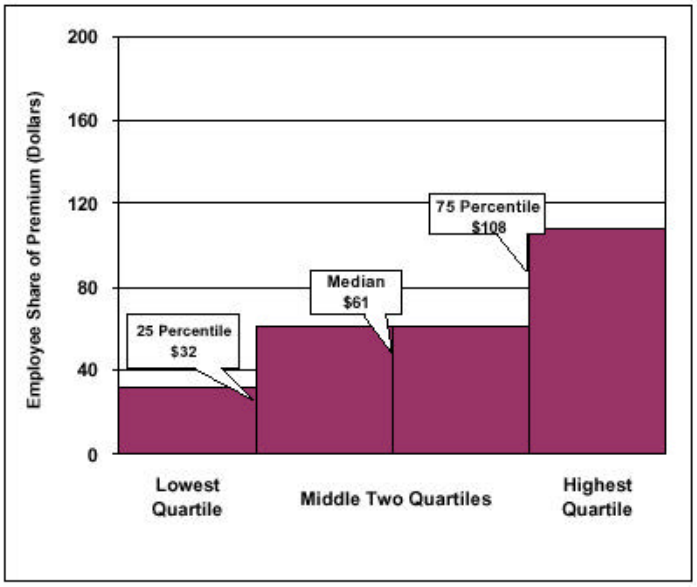
Cost of policies

This information was not obtained on the household survey, since employees often do not know the total premium costs.

Level of contribution

- The median employee share of employee-only health insurance premiums is $61 per month, with a mean of $173.

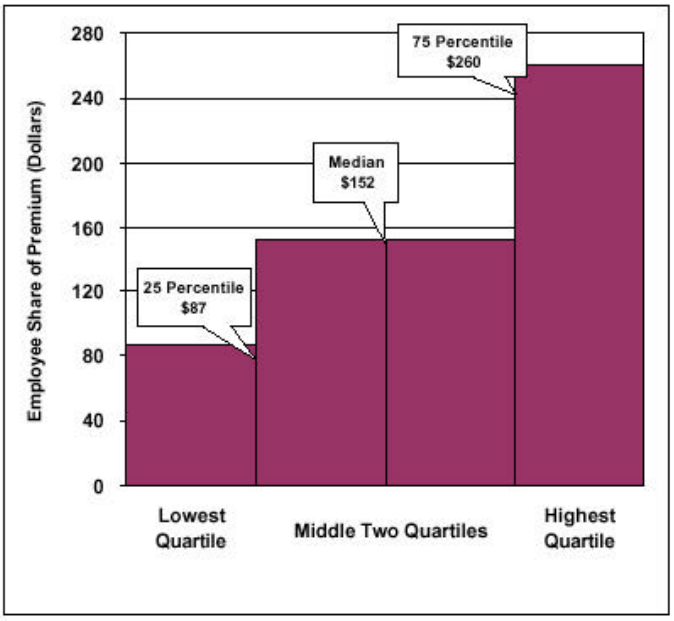
Figure 2.7: Monthly Employee Share of Premiums for Self-only Employment-Based Health Insurance Coverage.



Sample size for this figure = 964 individuals

- The median employee share of health insurance premiums for family coverage is $152 per month, with a mean of $225.

Figure 2.8: Monthly Employee Share of Premiums for Employment-Based Family Health Insurance Coverage.

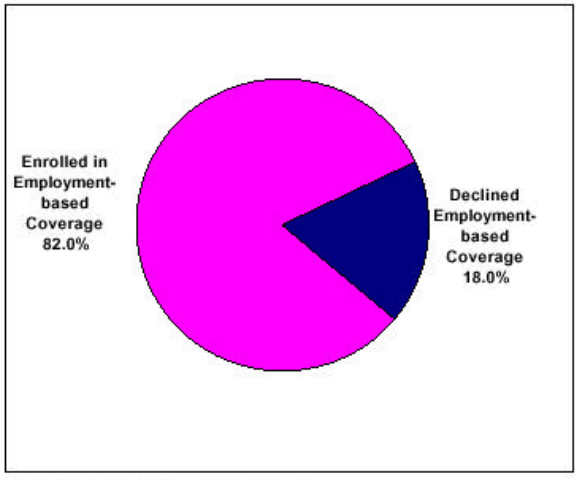


Sample size for this figure = 2,858 individuals

Percentage of employees offered coverage who participate

- Among Kansas residents age 18-64 eligible for employment-based insurance, 82% report they are enrolled in that coverage, while 18% report they declined employment-based coverage.

Figure 2.9: Enrollment of Employed Kansans Age 18-64 Who Are Eligible for Employment-Based Insurance.



Sample size for this figure = 10,602 individuals

Questions 2.2 through 2.7

Source of Information
Perspectives of Kansas Small Businesses, Insurers, and Brokers on Health Insurance—data collected from the 46 participants attending eight focus groups and 20 key informant interviews with small business owners, insurers, and brokers.

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing to provide coverage?

Those factors that employers described as supporting a decision to offer coverage included:

- A sense of obligation to employees, that it was the right thing to do.
- The need to remain competitive in the market. Offering coverage was important in attracting, recruiting, and retaining good employees.
- Business owners wanted coverage for themselves and their families.
- Offering insurance was a financial benefit to the business in that "healthy employees come to work."

Those factors that caused employers not to provide coverage included:

- Coverage was too costly, particular for small businesses.
- Business owners have it through a spouse so therefore do not need insurance.
- Employees do not need the insurance, e.g., they have insurance through a spouse; or they do not see the value of health insurance and would prefer higher wages.

Small employers also discussed specific barriers they encounter in trying to offer health insurance benefits. These included:

- Lack of clear and understandable information on health insurance, so they can make good purchase decisions.
- Prohibitive cost and lack of competition in small employer market.

2.3 What criteria do offering employers use to define benefit and premium participation levels?

- Small employers stated that the contribution strategy was heavily influenced by the amount the business could afford to pay.

- Many small employers have conversations with their employees to determine the amount the employees can and would contribute.

- Some small employers base their contribution on the "industry standard."

- Overall, health care provider choice was worth a lot to small employers, and they were typically unwilling to trade off choice for lower out-of-pocket expenses. An exception to this was low-income families with young children.

- Many small employers simply used the recommendation of their insurance agent.

- Some small employers with young single employees choose to pay 100% of health insurance premiums (since young, healthy employees may decline coverage), so they can reach insurer's minimum participation requirements or to get the most out of the federal tax advantage.

- Some small employers look for administrative ease, i.e., as little paperwork as possible.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

Although the focus group facilitators did not specifically ask this question, it can be assumed that any economic downturn or increase in premium costs would cause many small employers now offering a health insurance benefit to drop the benefit or to pass on additional costs to employees and those employers not currently offering benefits would be less likely to begin offering benefits, since:

- Small employers' chief concern in offering health insurance was the cost.

- One of the major determining factors affecting small employers' decisions to offer a health insurance benefit was whether their business could afford the cost.

2.5 What employer and employee groups are the most susceptible to crowd-out?

This question was not explored in the focus groups with small employer firms.

2.6 How likely are employees who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?

- Most small employers were in favor of pooled purchasing if it would mean better rates for them and if they could be treated as a "real group."

- The majority of participants were reluctant to give up their freedom to choose the insurer providing coverage and were very wary of government involvement in the administration of the potential group.

Individual or employer subsidies?

- Most small employers did not respond favorably to subsidies.

- Employers with large numbers of very low-wage employees thought something should be done to help them afford the employees' portion of the premium but reacted more favorably to expanded tax credits for employers so they could pay 100% of the premium versus a new subsidy.

Additional tax incentives?

- Most small employers believed that tax credits would be a significant motivation for employers who already want to offer health insurance but cannot because of the cost.

- Many believed tax incentives would be more desirable and helpful if they were adjusted annually for inflation, were in effect more than 5 years, applied to all businesses (not just new businesses), and covered at least 50-75% of the premium.

- Some small employers expressed concern with the complexity of tax credits, that the administrative burden to get the credit was greater than the monetary value.

2.7 What other alternatives might be available to motivate employers not mow providing or contribution to coverage?

- There was general consensus among participating small employers that less state government involvement is better, but some employers said they would welcome a state mandate that all employers offer coverage because they believed all employers should "carry their weight."

- Some small employers believed the state should do something to reduce the variability in insurance costs, including year to year, company to company, and employee to employee, by more effectively regulating insurers.

- Small employers thought the state should "level the playing field" between large and small businesses by providing subsidies or grants to cover the difference in premium costs.

Section 3
Summary of Findings:
Health Care Marketplace

Sources of Information
Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey: Insurance Component, 1998
Kansas Insurance Department Memo
State Employee Health Care Commission Communication regarding State Employees Plan enrollment
Social Rehabilitation Services Communication regarding Medicaid/HealthWave enrollment.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

Adequate is defined as a reasonable level of major medical coverage with reasonable deductible (less than or equal to $1000) and coinsurance (typically 20 to 30%) and few inside limits available with no exclusions for pre-existing conditions. The products currently marketed in Kansas are probably adequate for persons in middle to upper income levels who do not have pre-existing conditions and are under age 60. Current costs would preclude purchase by anyone in upper age brackets and/or lower income levels.

3.2 What is the variation of benefits among non-group, small group, large group and self-insured plans?

Non-group, small group and large group benefit structures for insured products tend to be similar in that most mandated benefits apply to all insured products. The major medical structure outlined above is the norm. The major difference in major medical products is that coverage for prescription drugs varies by plan. Some have complete drug coverage while others have little or no coverage for drugs. Self-funded programs would not have to offer any or all of the mandated benefits and may or may not include benefits for nervous and mental conditions, drug and alcohol abuse treatment, and other select services.

3.3 How prevalent are self insured firms in your State? What impact does that have in the State's marketplace?

Self insured firms are likely to be half or more of the health insurance market in the state including most major employers and the state of Kansas employee group. The impact on the marketplace is unknown in that we don't know who administers these plans or what provider networks are used.

3.4 What impact does your State have as a purchaser of health care?

The State of Kansas Group Health Insurance Plan covers over 90,000 lives. The Kansas Medicaid program covers 261,300 lives and of those covered 43,220 are children. The HealthWave Program (SCHIP) has a current enrollment of 23,353 children. In total, the state purchases health care coverage for over 373,653 Kansans and can be considered a major purchaser.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

One of the current market trends is that some carriers that offer coverage in the individual and small group markets are discontinuing offering coverage. The rapid increase in medical costs is the major factor. These trends make achievement of universal coverage less likely and although there exist regulatory approaches that could alter this course there is little support for such initiatives.

3.6 How would universal coverage affect the financial status of health plans and providers?

Universal coverage would positively affect the current health plans because it would reduce the overall anti-selection that is currently in the individual and small group market. Receiving little or no premium from those not in the insurance system increases the cost for those in the system to the extent that the insured have lower overall medical costs.

3.7 How the planning process take safety net providers into account?

From the beginning safety net providers have been an integral part of all aspects of grant implementation:

- The Executive Director for the Kansas Association for the Medically Underserved, an organization that has close interaction with safety net providers and represents Kansans whose access to health care is compromised is a member of the HRSA State Planning Grant Steering Committee. Members of this group have had input into all aspects of the research activities and plan development. Several other members of the Steering Committee also, have in-depth understanding of the perspectives of safety net providers that they have shared during the grant implementation activities.

- Safety net administrators and providers from each of the 10 state study regions were participants in the qualitative study component. These 10 groups (18 individuals) responded to the same questions asked of the uninsured participants, as to their views

as to what affects uninsured status as well as their ideas on solutions to reducing the number of uninsured in the state.

3.8 How would utilization change with universal coverage?

Utilization is likely to increase initially for those newly insured due to pent up health needs. The Kansas Health Insurance Study indicates that 16.3 percent of uninsured Kansans have never had insurance and another 34.8 percent have been without insurance for more than two years. In addition, the survey data highlights the impact of health insurance in seeking medical care with 40.8 percent of uninsured Kansans delaying or not obtaining needed medical care in the last year. It is anticipated that the early increase in utilization will level off and then decrease as more disease prevention and health promotion services are available to the newly insured.

3.9 How the experience of other States was taken into account with regard to:

Expansion of public coverage:

The Steering Committee examined in-depth the experiences of various states that were using Medicaid 115 waivers to change a variety of the provisions of Medicaid or SCHIP program; those that were using Medicaid Section 1931 provisions to disregard portions of applicants' incomes; states that had in place state finances expansions; and those adopting public program buy-ins. In addition, the approaches used by the nineteen states expanding public programs to parents of enrollees were investigated.

Public/private partnerships:

Health Insurance Premium Payment (HIPP) Programs:

- Reviewed experiences of states that used public insurance funding to subsidize the employees' premiums for Medicaid and SCHIP eligible individuals. Specific state HIPP programs considered were IA, WI, MO, and TX.

- Four states, MA, WI, MD, WY, have implemented HIPP programs using SCHIP funding. Although too new to evaluate their effectiveness several had designed administrative processes that may be useful.

Community Health Center (CHC) Facility-Based Insurance:

- There are 21 CHC managed care programs in 15 states. Three, Colorado Access, Community Choice Michigan, and First Guard Missouri, were reviewed in detail to evaluate the feasibility of such a program in Kansas.

Incentives for employers to offer coverage:

Tax Credits for Small Businesses:

- Reviewed Maine's employer tax credit for dependent health insurance coverage.

Expansion of state employee health benefit program:

- Reviewed Georgia's program that provides access to state health insurance for rural hospital employees, called "critical access hospitals."

Health Reinsurance Programs:

- More than 50% of states have passed some form of a reinsurance law
- A small number of states have recently or are currently using health reinsurance to improve the functioning of their small group and individual market. Primary examples considered are AZ and NM.

Regulation of the marketplace:

Adjusting initial waiting period:

- A number of states have eliminated or shortening the initial waiting period for health insurance plans and their approaches were reviewed.

Extension of dependent coverage age limits

- Approaches of states on setting dependent age limits were examined.

Section 4
Summary of Findings:
Options for Expanding Coverage

The Steering Committee began to receive information from the various research component studies in May, 2001 when preliminary data findings from the Employer Focus Groups and Interviews and from the Key Informant Interviews with Uninsured Kansans were presented.

Initial results of the Kansas Health Insurance Survey were presented to the Steering Committee in July, 2001 and the comprehensive report was distributed to committee members in August, 2001. The Steering Committee has selected a number of policy strategies to examine in depth but no decision has been made about adoption of any specific coverage expansion strategy. An extension of the grant was sought to allow for garnering public input, further consensus building activities, and examination of the raw data now that data files have been released to the state.

No coverage options have been selected at this time so Section 4 responses will focus on questions 4.16-4.18 and 4.19 as instructed.

4.16 Expansion options currently being given strong consideration:

Early in the implementation process the Steering Committee reached consensus on a set of principles that would be used to guide the selection of policy options contained in the strategic plan to provide health insurance coverage to all Kansans:

- Maximize federal dollars
- Subsidization will be needed
- Utilization of the employer based coverage is the preferred route
- Role of individual responsibility needs to be incorporated
- Comprehensive wellness focused benefit package
- Health insurance should not be mandated for individuals to carry or employers to provide

Those principles coupled with the information supplied about the uninsured have moved certain policy options to the forefront in the Steering Committee discussion. The Kansas Health Insurance Survey provides strong evidence that the vast majority of uninsured Kansans have a linkage to the employment system (95%). The expansions under serious consideration by the Steering Committee are those options that will strengthen the ability or provide incentives to employers to offer health insurance and enable employees to accept employer offered health insurance. The primary target of these options will be small employers and low-wage workers. It is anticipated that the cumulative effect of these multiple strategies will be most useful in achieving these goals. The policy options currently under discussion include:

Tax credits

Description of the option: Currently the Kansas Employer Tax Credit program is underutilized and relatively unknown to Kansas employers and employees. The program provides a tax credit of $35 per employee per month for employers who have not previously offered health insurance in the workplace.

In Phase I, an enhanced program would include targeted marketing and technical assistance to both employers and employees and insurance brokers. In Phase II, the program would expand the size, scope, and length of time of Kansas' current small business health insurance tax credit. The enhanced program could be linked to an expanded Health Insurance Premium Payment program (HIPP) to provide access to health coverage opportunities previously unavailable to the employee.

Target population: Low income Kansans employed at small businesses that do not offer, do not subsidize, restrict eligibility for, or are considering eliminating employee health insurance.

Advantages: The primary advantages are that it provides assistance to small employers, builds upon an existing policy, and has predictable costs. Since it is a market-based approach, the role of government is minimized.

Disadvantages: Tax credits must be large enough to significantly lower the employers' out-of-pocket expenses for subsidizing the coverage. For individuals to "take-up" coverage at a significantly higher rate, this price point must be greater than 50%; for employers to offer coverage they also will require a similar level of support. To expand the program, will be expensive and administratively complex. It is also potentially inequitable if employers who are currently offering health insurance, are not offered the tax credit.

Subsidized employment-based coverage buy-in

Description of the option: Expanding private, employer-based health insurance coverage by subsidizing employee premiums with Medicaid and HealthWave dollars. Kansas has a small Medicaid Health Insurance Premium Payment (HIPP) program. The Medicaid HIPP program would be expanded in combination with a SCHIP premium subsidy program for the purchase of employer-based coverage.

Target population: Low-income workers and their families, who are eligible for Medicaid and Health Wave under current or newly expanded criteria, and work for an employer who offers health insurance for which the worker is eligible.

Advantages: The primary advantage is the application of combined federal, state and employer funding streams to assist the uninsured low-income workers to purchase employer-based private coverage. It increases the likelihood that small employers will reach the required participation thresholds for group insurance coverage. In combination

with Medicaid and HealthWave expansions, it could provide access to health insurance for additional low-income Kansans. Finally, the new federal flexibility waiver may allow for tailored benefit packages and administrative simplification.

Disadvantages: The primary drawback is that HIPP programs are administratively complex for both the employers and for the state. While Medicaid HIPP programs have fewer restrictive federal rules than SCHIP HIPP programs, previous state experiences indicate considerable planning is required in the start-up phase and for ongoing maintenance.

Reinsurance for small group market

Description of the option: Establishes a new financing mechanism to insure against the losses incurred by health insurance plans in Kansas due to medical costs associated with the most expensive patients and protect individuals and small employers from market volatility. All health insurers would fund a state-subsidized reinsurance tool for all Kansans covered in small groups or as individuals, and the pool would pay for the cost of care above a certain amount per-person or group. Public subsidy could supplement insurer-based funds.

Target population: This option is designed to stabilize and expand coverage for Kansans who work for small businesses that don't offer, subsidize, or have broad eligibility for health insurance. It is also designated to make similar improvements to the individual health insurance markets.

Advantages: This has the potential to provide real stability to the fluctuating small group and individual health insurance markets. Kansas has higher than average coverage rates in small business employment and individual markets. This option can limit medical underwriting or make it "invisible" to individuals. It may also encourage smaller insurers to write more plans.

Disadvantages: It has the potential to be most effective if used in combination with other strategies that include subsidies. If not structured properly it can encourage the overuse of health care services.

Enhanced Business Health Partnership

Description of the option: The goal of increasing insurance provision rates among small employers was part of the Kansas Legislature's intent in 2000 when it authorized the selection of a private, nonprofit organization to serve as and operate the Kansas Business Health Partnership ("Health Partnership"), a health insurance purchasing pool that would provide a choice of health plans to workers in small businesses.

The innovative, and perhaps unique, aspect of Kansas' strategy was the deliberate development of a mechanism with the express purpose of combining several sources of payment—state (and, potentially, federal) tax credits, other direct public subsidies using

Medicaid and SCHIP funds, and traditional employer and employee contributions—to provide affordable coverage for low- and modest-wage small-firm workers and their families. The Business Health Partnership currently is not operational and the Steering Committee is discussing the application of certain policy options that might be supportive.

Target Population: Although any small employer (with at least two and no more than 50 employees) will be permitted to enroll in the Health Partnership, its primary target is the approximately 33,000 small businesses in Kansas that do not now offer health coverage, and their approximately 128,000 workers. The initial goal for the Health Partnership will be to enroll 20,000 or more small-firm workers and their dependents within two years after enrollment commences, with at least half of these enrollees low-income previously uninsured.

Advantages: The Partnership was established under the premise that the combination of a private, business-friendly organization like the Partnership, together with state and federal subsidies for low-wage workers and families and tax credits for previously uninsured small firms, will extend subsidized health insurance to many previously uninsured small businesses and their low-wage workers. It was anticipated that this investment would have a leveraging effect, extending affordable health insurance (without subsidy other than existing federal tax preferences) to higher income uninsured workers in these small firms.

Disadvantages: Creating the structure, operating rules, and subsidy fund transfer mechanisms is complicated and has taken more time than originally anticipated.

Medicaid and Healthwave enhancements to increase enrollments

Description of the option: Identify and implement regional level enrollment and retention enhancements of the Medicaid and HealthWave program.

Kansas provides coverage for children up to 200% FPL, through either the Medicaid program or Health Wave. The household survey indicated regional variation in the number of uninsured children, eligible for public program coverage.

Target population: Kansas uninsured children less than 200% FPL, who are eligible for coverage under Medicaid or Health Wave.

Advantages: Provide coverage for children who are currently uninsured, strengthen regional enrollment strategies, provide access to families for coverage under the expanded HIPP program enhancements.

Disadvantages: Increased costs to the state Medicaid and SCHIP program.

Medicaid program expansions

Description of the option: Raise income eligibility levels for adults in Kansas Medicaid program. Currently Medicaid eligibility is at 43% Federal Poverty Level.

Target population: Parents of Medicaid children who are below the federal poverty level, and are not employed.

Advantages: Provide access to health insurance coverage to Kansans who do not have health insurance, and can not afford to purchase.

Disadvantages: Increased cost to the state Medicaid program, expansion of state program in a political climate that is financially stressed.

Facility-based health insurance coverage

Description of the option: A new facility or provider-based mechanism for delivering health care and providing health insurance coverage. This option is designed for Kansans preferring to receive health care through the Community Health Centers than the traditional health insurance system. The state would contract with the facility-based entity, most likely a Community Health Center partnership, to provide the array of services specified by the benefit package design for enrollees.

Target population: Uninsured low-income Kansans who are unable or reluctant, for any reason, to participate in traditional private or public health insurance options but now use clinics as their source of care. This likely includes a large number of immigrant families, as well as farm and migrant workers, who have high uninsurance rates and may be eligible for existing public insurance programs.

Advantages: This option would fill a very difficult coverage gap, while building on a health care system that is in place in the state. It would encourage primary and preventative health care in a population that has had limited access to those services. Coordination of services would be enhanced since the facility-based entity would provide a medical home for enrollees.

Disadvantages: The primary challenge for the Kansas Community Health Centers is their fiscal instability, lack of administrative capacity, and limited experience in offering a comprehensive insurance product. This option would require an expansion of the role of the clinics and the development of a sophisticated infrastructure and network. It also diverges from Medicaid philosophy of promoting beneficiaries' access to mainstream health care providers.

State employee health plan

Description of the option: To expand access to health care insurance through the state employee health plan for selected groups of Kansans in small business settings.

The statute authorizing the structure of the Kansas state employee health plan, included the ability to expand to selected employment groups. Currently the plan provides coverage for active and retired state employees, and public school districts. Other employee groups that can be added are: licensed child care facilities providing residential group foster care for children, community mental health centers, community facilities for the mentally retarded, and independent living agencies.

Target population: Individuals working for small employers in the agriculture sector.

Advantages: The statute currently provides access to the state employee health plan by a broader set of employee groups, and this extension would target a sector that has difficulty securing insurance due to adverse risk rating.

Disadvantages: Increased costs to the state employee health plan at a time when the costs are rapidly escalating. There is also a cultural resistance to adding other "groups" who are perceived as being at higher risk to the state employee pool.

Health insurance regulatory modifications

Description of the option: Enhancing standard health insurance policies in Kansas to eliminate or reduce certain rules that affect access to coverage.

Elimination or increase of the maximum eligibility age for dependent children covered under a family health insurance plan is being examined. The second policy modification under consideration is the shortening of the initial waiting period for coverage that is commonly at 120 days or more in many health insurance plans.

Target population: The first rule change is targeted to young adults, who have the highest rates of being uninsured of any age group. One of every five Kansans age 19-24 is uninsured. The second change is focused on new workers who often go temporarily without health coverage.

Advantages: There are limited additional costs to insurers associated with extension of dependent coverage age since this group is considered low risk.

Disadvantages: There is resistance to insurance mandates.

4.17 What has been done to implement the selected policy options?

The previously mentioned policy options are currently being evaluated by the Steering Committee and at this time no decision has been made as to their inclusion in the plan. Input will continue to be sought from a broadly and that will influence the final outcome as to plan elements. The group is in the process of sharing the research findings and policy options under consideration with stakeholders, legislators, and the public.

4.18 What policy options were not selected?

No options have been rejected at this point except for those that fail to adhere to the principles established by the Steering Committee early in their deliberations, such as mandates.

4.19 How will your State address the eligible but unenrolled in existing programs?

The Kansas Health Insurance Study provides evidence that a majority of uninsured children are in families with incomes below 200 percent of the federal poverty level, the eligibility level of our HealthWave program. The Steering Committee is in the process of looking at regional variation patterns and comparing the enrollment and outreach activities of those regions that are performing well with those performing poorly. From this comparison will emerge a set of strategy that will be recommended in the plan to improve enrollment in the public programs.

Section 5
Summary of Findings:
Consensus Building Strategy

5.1 The governance structure used in the planning process and its effectiveness as a decision-making structure:

The Kansas State Planning Grant from its beginning has had in place a governance structure that has been actively involved in all phases of the planning process. This 22-person steering committee was appointed and is chaired by the Kansas Insurance Commissioner. It is a broad-based group drawing members from the public and private sectors with representatives from the legislature, the governor's office, the hospital association, the medical society, nursing, the Hispanic community, the Chamber of Commerce, small employers, consumers, a philanthropic foundation, research community, governmental agencies, and academic institutions.

This broad based group has brought a variety of perspectives to the planning process and also afforded opportunities for interaction with others across the state. For example, the president of the Kansas Hospital Association, in a weekly newsletter to constituents highlighted the activities of the State Planning Grant so that members would be aware of the initiative and the data findings.

The State agencies most involved in health issues have high level representatives on the Steering Committee, including the: Director of Health Policy, SRS who has responsibility for administering the Medicaid program and the Department of Health and Environment State Director of Health who oversees a broad range of health programs, including Title V. In addition, the governor is represented by his legislative liaison.

5.2 Methods used to obtain input from the public and key constituencies:

The Kansas State Planning Grant (SPG) project adopted a two-phase consensus building strategy.

Phase One: The first phase included formation of a project governance structure that included membership of key public and private sector representatives. This group was actively involved in all aspects of the grant implementation process; including advisement on research activities, selection of operating principles, receipt of data findings, selection of plan direction, and prioritization of plan options.

Also, during Phase One, expert input was sought through a series of three meetings where industry leaders (insurance firm executives, brokers, agents, and small employers) repeatedly met. The experts in these sequential meetings discussed issues surrounding uninsured Kansans, identified contributing factors, discussed potential remedies, and

provided feedback about the policy options currently being considered by the Steering Committee.

Phase Two: The second phase of the consensus building strategy is currently in progress and has a goal of both providing information about uninsured Kansans recently revealed by the project research activities and eliciting feedback about the policy options under consideration by the Steering Committee. This is being done through a series of public meetings across the state, through presentations to various stakeholder groups, and by the provision of testimony to various legislative committees. The ideas provided by attendees at these various forums will be discussed by the Steering Committee and result in further refinement of the evolving policy plan.

In addition, the four major health foundations in the state are planning a future dissemination conference with statewide representation of a broad array of community leaders and stakeholders to discuss the issue of the uninsured in Kansas and strategize about ways to promote action in dealing with this problem, highlighting the work and products developed through the State Planning grant.

5.3 Other activities to build public awareness and support:

The Kansas Insurance Department has worked actively with the media to issue periodic press releases on the project so that the public will be aware of the grant activities, research findings, and the plan options under current consideration. The meeting schedule has been publicized and generally there have been multiple non-Steering Committee members in attendance. The Department has also established a dedicated web site on their home page so the public can access meeting minutes, PowerPoint presentations, and documents that have been utilized during Steering Committee meeting deliberations.

5.4 How the planning effort has affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The Steering Committee has operated on the premise that implementation of the comprehensive plan for covering uninsured Kansans developed by the committee is both likely to take longer than the five years planned and will undergo considerable modification. The plan provides for policymakers some concrete ideas, targeting various subpopulations of uninsured Kansans that over time reduce the magnitude of the problem. The group has attempted to build upon existing policy approaches when available and build incremental improvements into the plan so that these options perform better in getting more citizens health insurance but at the same time are implemented in a fashion that is affordable.

Two aspects of the current policy environment have potential for considerable influence on the probability that the coverage expansion proposals will be implemented in full:

- 2002 is not only an election year, but also a year when all statewide elected officials, including the governor and the entire House of Representatives will be chosen
- Kansas faced tight fiscal constraints during the last year and projections for next year indicate a worsening financial picture.

In addition, there is considerable uncertainty in the insurance market with a number of carriers writing individual policies leaving the state and the pending sale of Kansas Blue Cross and Blue Shield. The climate is further impacted by steep increases in health insurance premiums for the majority of employers and an economic downturn that has resulted in sizable layoffs by several major employers in the state.

Section 6
Summary of Findings:
Lessons Learned and Recommendations to States

6.1 How important was State-specific data to the decision-making process?

Data has become available to the Steering Committee relatively recently, but it is clear that the availability of accurate state-level data about the uninsured is very helpful in creating targeted policy solutions. Up to this time, Kansas relied almost exclusively on information produced through national surveys and those surveys were several years old and provided very limited information about the uninsured in our state. The data collection initiatives supported by the State Planning grant allow us to develop detailed profiles of the uninsured at both a state and regional level so that policy can be targeted in very specific ways to address the various aspects of this complicated problem. The qualitative research components of the grant were helpful in giving depth to our understanding of the numbers provided in the survey research. Those findings provided additional insights into the experiences of the uninsured and the struggles small employers were facing in trying to find affordable health insurance.

6.2 Which of the data collection activities were most effective relative to resources expended in conducting the work?

Kansas was fortunate in the selection of the venders for the various research components. All were expert in their endeavors and delivered quality products that collectively provided needed information for the development of relevant policy approaches.

6.3 What if any data collection activities were originally proposed or contemplated that were not conducted?

All data collection activities identified in the original Kansas proposal were completed.

6.4 What strategies were effective in improving data collection?

One key factor contributing to the success of the quantitative data collection initiative was timely input from the Steering Committee during the planning phase on various aspects of the survey design, including identification of regional boundaries, key populations for over sampling, and instrument content and wording. In addition, success was achieved through the partnership of a local research team and a vender with experience in this field who strategized about ways to maximize response rates. The qualitative data endeavors were again positively impacted by input of Steering Committee members and their contacts in assisting the researchers in linking with key informants across the state.

6.5 What additional data collection activities are needed and why?

The Kansas State Planning Grant research activities provided extensive information about the uninsured in our state through the combined input of data gained through the large household survey and the additional understanding provided through in-depth interviews with uninsured Kansans. On the employer side the sole data source was focal groups and key informant interviews with small employers, brokers, and representatives of the insurance industry. Since most Kansans access health insurance through the employment setting, the addition of a quantitative data collection initiative with Kansas employers would provide important information about the supply side of the problem. Currently there is no plan to undertake this research.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes to the structure of health care programs or their coordination as a result of the HRSA planning effort?

The Kansas project is in the preliminary stages of coverage expansion proposal selection. We are currently examining our data, developing a list of potential strategies, and estimating their costs. As the Steering Committee discussion has progressed a number of structural impediments in existence in current programs have been identified, such as the difficulties involved with the tax credit due to shared responsibilities between two state agencies. The final plan is likely to contain recommendations for changes in process operations.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort?

The Kansas Health Insurance Study provided valuable information about sources of health insurance for the state and for ten regions. There exists considerable variation across regions in the proportion of Kansans covered by employer, individual, and public insurance products. Currently, the Steering Committee is examining these differences to ascertain if targeted policy initiatives might have merit. The Perspectives of Kansas Small Businesses study provided needed information about the depth of the commitment of employers to provide health insurance to their employees and the amount of time required to obtain that coverage.

6.8 What are the key recommendations that your State can provide to other States regarding the policy planning process?

Our state is in the early stages of developing our policy plan, but already the value of having experts to facilitate that process is apparent. The contracted entity has provided invaluable assistance in clarifying policy approaches, quantifying their impact, and suggesting alternative mechanism.

Section 7
Summary of Findings:
Lessons Learned and Recommendations to States

The policy options to be included in our plan have yet to be selected so it is unknown at this time if changes in federal law will be required.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

Access to state level data that has specificity is vital for the crafting of relevant policy and the state planning grant has given Kansas an opportunity to have such data for the first time. We now have baseline data and it would be very helpful to have similar information in subsequent years to evaluate if the current situational conditions have had an impact on insurance status and if the enacted policies have made a difference.

7.4 What additional research should be conducted to assist in identifying the uninsured or developing coverage expansion options?

Detailed information about self-insured firms would be useful since there is currently little data available and much of it is anecdotal.

Appendix I
Baseline Information

Population:

- The total population in Kansas is 2,688,418
- From 1990 to 2000 the state has experienced a net increase of 211,000 people or 8.5%
- Kansas is expected to gain about 102,000 people through international migration between 1995 and 2025; only a net gain of 7,000 persons is expected through internal migration during the same period
- There is considerable variability in population across the state. The population of Kansas is most dense in Region 2, which includes one eastern county, and least dense in the North and Southwest counties, which include 21 and 25 counties respectively

Number and Percent of Uninsured:

- The uninsured rate for the non-elderly in Kansas has been consistently below the national norm since at least 1987
- Analysis of the March 1999 Current Population Survey (CPS) by the Employee Benefit Research Institute indicated that 12.2% of non-elderly Kansans were uninsured in 1998, the 11th lowest rate in the nation for 1998
- The uninsured rate for 1998 decreased 1.5 percentage points from the 13.7% rate found in 1997

Average Age of Population:

- Overall the age structure of Kansas is not unlike that of the United States, with the largest percent between ages 18-64 and lowest percent at less than 5 years
- The state's urban counties, Region 1, 2, 3, and 6, generally have low concentrations of older residents, with only 10.9% of the population over age 64. In the remaining regions, both rural and frontier, percent over age 64 ranges from 12.7% to 19.7% in the Northwest.

Ethnic Distribution:

- Overall, the largest ethnic group identified by individuals in Kansas was Whites, at 87.9% and the smallest was Pacific Islander, at 0.1%
- Several of the Regions are more diverse than statewide averages. Blacks and Hispanics constitute more than a third of the population in Region 1 (Leavenworth-Wyandotte counties) and Hispanics constitute more than a quarter of the population in Region 10 (Southwest)
- The high proportion of "other" responses in that region appears to reflect the replies of Hispanic residents

Percent of Population Living in Poverty:

- Approximately 10.9% of the Kansas population lives in poverty
- There is considerable regional variability related to poverty, with the lowest percent in Region 2 (3.9%) to a high of 15.7% in region 1

Primary Industries:

- Overall, 73.7% of Kansas businesses have nine or fewer employees; only 5% of Kansas businesses have 50 or more employees
- There is some variation in the percent of small firms between regions, with a high of 81.7% small businesses in Region 9 and a low of 67.8% in Region 1.
- According to the 1999 Census the largest percent of industries in Kansas are retail trade industries, at 16.5%, other services, at 11.3%, and construction, at 10.3%
- Less than 1% of Kansas industries are in utilities, management, forestry and agricultural support, education, and auxiliary
- Farming, even in Kansas rural counties, represents a small share of total employment. For the state as a whole, farm jobs make up only 4.6% of total employment, with a high of 13.2% in the Northwest Region and 12.7% in both the Southwest and Northeast Regions

Number and Percent of Employers Offering Coverage:

- According to the 1999 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) 58.1% of private sector business establishments in Kansas, approximately 42,914 businesses, offer health insurance
- This percent is lower for small Kansas businesses of less than 50 employees, at 47.7%, which includes approximately 27,638 businesses
- Approximately 15,090 large Kansas businesses (over 50 employees) or 96.6% offer health insurance to their employees.

Number and Percent of Self-Insured Firms:

- Of the 42,914 private sector businesses that offer insurance in Kansas, approximately 27.7% or 11,887 are self-insured
- Only 16.3% of small businesses (approximately 4,505 businesses) offer insurance and are self-insured; 48.5% of businesses over 50 employees or approximate 7,319 businesses, offer insurance and are self-insured.

Insurance Market Reforms:

- In mid-1980s, health insurers operating in Kansas were required to offer 6-month continuation of group coverage for people leaving an insured group of any size

- In 1991 required insurers to accept or reject entire groups that applied to them for coverage, required insurers to guarantee issuance of coverage to new enrollees joining an already insured group, standardized definitions affecting exclusion of coverage for pre-existing conditions, limited such exclusions to a maximum of 90 days, and required insurers to give new enrollees credit if they had prior coverage
- In 1992, reforms enacted to guarantee all small employers access to "standard and basic" plans and to establish uniform rating standards fro small employer plans
- In 1992 the legislature established the Kansas Health Insurance Association (KHIA), a "high-risk" pool
- In 1997 the federal Health Insurance Portability and Accountability Act (HIPAA) was implemented and small employers were guaranteed access to all insurance plans offered by carriers
- Enacted tax incentives for small employers in 1992. This was revised in 2000

Eligibility For Existing Coverage Programs (Medicaid/SCHIP/other):

- Pregnant women and infants are currently eligible for Medicaid or HealthWave up to 200% FPL
- Children age 1-18 are eligible for Medicaid or HealthWave up to 200% FPL
- Parents of Medicaid and HealthWave kids and single or childless couple are eligible for Medicaid up to 43% of FPL

Appendix II
Links to Research Findings and Methodology

The Kansas Insurance Department has the lead role in the HRSA State Planning Grant, and developed a link on their home page (http://www.ksinsurance.org) to provide ongoing information to the public. The grant website, which is entitled *Making Insurance Affordable for All Kansans*, is located at http://www.ksinsurance.org/index.php?id=0174 . The content on the site includes:

- Overview of the HRSA Grant
- Steering Committee Members
- Schedule of Public Meetings
- Slide Presentations from the Public Meetings
- Press Releases
- Research Reports

The final research reports will be linked to the site and accessible as a downloadable PDF files. The statewide household survey, "*Finding and Filling the Gaps: Developing A Strategic Plan to Cover All Kansans",* is currently available. The qualitative study of key informant interviews with uninsured Kansans, "*Voices of the Uninsured: Kansans Tell Their Stories and Offer Solutions*", and the qualitative study of focal group and interviews with small employers, insurers, and brokers, "*Perspectives of Kansas Small Businesses, Insurers, and Brokers on Health Insurance,* will be available before the end of the year.